California Department of Health Services

2004 Public Forums on Heart Disease and Stroke Prevention and Treatment

DRAFT

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ACKNOWLEDGEMENTS

The California Heart Disease and Stroke Prevention Program (CHDSP) would like to acknowledge the many organizations and individuals whose contributions of time and resources made the seven regional public forums on heart disease and stroke prevention and treatment possible.

First, CHDSP would like to recognize the individuals who served on planning committees in each location. The planning committees identified local experts who served as panelists, promoted the forums to local stakeholders, advised on logistics and, in other critical ways, established the framework that supported the forums. Without the assistance of these committee members, CHDSP could not have completed this project.

Second, the panelists who attended the forums were exceptionally generous with their time. In each region, the gathering of the top tier professionals in cardiology, neurology, public policy, public health, healthcare, health education, nutrition, and land use planning was unprecedented, and testified to California's commitment to cardiovascular health.

Financial support for the forum series, and for the convening of the California Heart Disease and Stroke Prevention and Treatment Task Force, was provided by generous grants from the American Heart Association and Kaiser Permanente, and by an unrestricted educational grant from AstraZeneca.

Across the state, organizations and institutions literally opened their doors to this effort. Kaiser Permanente San Francisco Medical Center, UC Davis Medical Center, UC San Diego Medical Center, the American Heart Association Western States Affiliate, the San Bernardino County Medical Society, and the Humboldt Area Foundation generously hosted forums at their facilities. Meeting space in Fresno was provided courtesy of a donation from the California Health Collaborative.

The Task Force will have an opportunity to actually view two of the forums: Inland Empire and Sacramento. CHDSP is grateful to Kaiser Permanente Fontana, who paid for videotaping of the Inland Empire forum, and to UC Davis Medical Center, who videotaped the Sacramento forum.

This forum series, like all successful projects, was the product of many minds and collective energy. On behalf of the Californians who will ultimately benefit from this project, CHDSP sincerely thanks all who were involved.

PREFACE

More Californians die each year from cardiovascular disease (CVD) than from the next four leading causes of death combined. Over the past two decades, important studies have helped define accurate clinical tests, risk factors, preventive interventions, and effective therapies for CVD. Unfortunately, Californians continue to die or become disabled as a result of CVD.

In 2003, California's leadership demonstrated its willingness to take action against this immense health problem by passing Assembly Bill (AB) 1220, introduced by Patty Berg (D-Santa Rosa). AB 1220 establishes a 12-member Heart Disease and Stroke Prevention and Treatment Task Force to write a State Master Plan to reduce morbidity, mortality, and the economic burden of CVD in California. The bill requires that the California Department of Health Services (CDHS) assist the Task Force in its work, and mandates that all expenses associated with writing the Master Plan be covered by private or federal funds.

CDHS has asked the California Heart Disease and Stroke Prevention Program (CHDSP) to take the lead in implementing AB 1220. Funds to support the operations of the Task Force have been donated by the American Heart Association, Kaiser Permanente, and AstraZeneca. In preparation for the first meeting of the Task Force, CHDSP held seven regional public forums to collect input from heart disease and stroke stakeholders across the state. This report summarizes the proceeding of those forums.

Structure of the California Heart Disease and Stroke Prevention and Treatment Public Forum Report

This report summarizes the recommendations of health experts throughout California to reduce death, disability, and the economic burden from heart disease and stroke. The body of this report is organized into three sections:

- Background and Methods For the Development of the Public Forums
- Executive Summary: Highlights from All Public Forums
- Site-Specific Public Forum Reports, each with 4 subsections:
    - Summary of Key Findings
    - Tables with Panelists' and Public Comments
    - Panelists' Biographies
    - State and Local Contact Information

BACKGROUND AND METHODS FOR THE PUBLIC FORUMS

CHDSP History and Background

CHDSP evolved from the Cardiovascular Disease Outreach Resources & Epidemiology Program (CORE). CORE was initiated in 1993 by the CDHS and the Institute of Health and Aging at the University of California, San Francisco. After two decades of decreasing mortality rates from CVD, heart disease and stroke were still the number one and number three leading causes of death in California. CORE dedicated itself to increasing awareness of the problem of heart disease and stroke in California by analyzing existing data to assess state trends of CVD mortality in the state.

In 2001, the CHDSP Program was launched to meet growing needs in secondary prevention of heart disease and stroke. *Healthy People 2010* addresses 16 objectives regarding coronary heart disease, heart failure, stroke, hypertension, and total cholesterol levels, including preventing second cardiovascular events. Many programs at CDHS are providing education in the areas of risk factors for heart disease and stroke in primary prevention, including nutrition, smoking cessation, diabetes, obesity prevention, and physical activity.

Public Forums: Developing the Infrastructure

To facilitate the development of a state Master Plan by the Task Force, the CHDSP launched public forums in seven areas of the state to gather critical local input from experts on heart disease and stroke prevention and treatment. The public forums were held in *Eureka, Fresno, Los Angeles, Sacramento, Inland Empire*, *San Francisco,* and *San Diego* and were designed to reveal the scope of the CVD burden in communities and the innovative ideas of experts regarding heart disease and stroke prevention.

The Public Forums: How They Were Organized

CHDSP organized each forum with assistance from local planning committees. The planning committees, made up of recognized community leaders who have a vested interest in heart disease and stroke, identified potential expert panelists who were contacted by CHDSP staff. A concerted effort was made to recruit expert panelists from the fields that are represented by Task Force members (e.g. cardiology, neurology, public health, research, healthcare administration, disparate populations, nutrition, disease survivors). In all cases, CHDSP and the planning committees carefully selected each panel to represent a wide range of knowledge, expertise, and experience. Up to 14 stakeholders were invited to be panelists at a two-and a half-hour public forum. The forums were open to the public and included a short period for comment at the end of each forum. Written comments were also encouraged.

CHDSP contracted with The Public Health Institute's (PHI) Center for Collaborative Planning (CCP) to provide planning, facilitation, and documentation services for the implementation of the public forums. Specifically, CCP participated in the public forum planning committee meetings; provided a professional facilitator to engage forum participants in responding to key questions and issues and a note taker to take detailed notes; handled the meeting logistics (flight arrangements, car rentals, meeting room arrangements, audiovisual equipment); and coordinated the dissemination of invitations and press releases via e-mail. CCP was also charged with drafting and formatting the public forum report.

To inform the public about the public forums, CHDSP, the Planning Committees, and CCP sent "Save the Date" fliers and press releases to state representatives, county supervisors, and local media outlets, including print, radio, and TV through Congress.org.

At each public forum, the expert panelists and the public were asked to respond to five questions. The five questions are specific to the five goal areas that the Centers for Disease and Control and Prevention (CDC) designate for the development of a state heart disease and stroke prevention and treatment plan. The panelists received the five questions in advance of the forum and were invited to address any or all of the questions. The questions were also available to the public in advance upon request, and at the public forum. Each of the five questions was allocated 25 minutes of discussion time.

In addition to gaining insights from experts on heart disease and stroke from throughout California, the public forums accomplished two other very important functions:

1. The public forums provided a venue for stakeholders in the various communities to come together (sometimes for the first time) to recognize important opportunities for collaboration. To encourage this, CHDSP compiled a list of local stakeholders with contact information and materials that were distributed to forum panelists and public attendees.

2. The public forums contributed to the development of a statewide infrastructure that will be critical to the implementation of the Master Plan. CHDSP has developed a database of individuals, institutions, and community-based organizations who are committed to the control and prevention of heart disease and stroke and are willing to address those parts of the state plan that are consistent with their missions.

Copies of this report are available from the California Heart Disease and Stroke Prevention Program. Call 916-552-9870, mhinojos@dhs.ca.gov, or visit www.calheart.org.

EXECUTIVE SUMMARY: HIGHLIGHTS FROM THE PUBLIC FORUMS

At each public forum, expert panelists and the public were asked to respond to five questions. The five questions were aimed at the five goal areas that the CDC has designated as vital to the development of a state heart disease and stroke prevention and treatment plan.

Question number 1: What are the three most important changes in California that need to be made in order to reduce death and disability from heart disease and stroke?

Panelists and community members identified seven broad categories regarding the changes that must occur to reduce death and disability from heart disease and stroke. These categories included: Prevention, Education, Research, Physical Activity, Healthcare Reform, Nutrition, and Environment. Highlights from the public forums include the following:

Prevention

- A public health approach, with input from communities and stakeholders, is needed to prevent the risk factors that lead to heart disease and stroke.
- Develop, value, and fund prevention strategies that include a healthy eating campaign, education about the importance of physical activity, and opportunities to continue and expand tobacco cessation efforts. The emphasis must be on disease prevention and lifestyle changes.
- Improve methods of educating healthcare professionals on new hypertension and lipid management guidelines.

Education

- Create a statewide, large-scale, public education campaign that focuses on cardiovascular disease as a leading killer, the major risk factors for heart disease and stroke, and risk-reduction strategies.
- Target education to high-risk populations, such as women and African Americans, who are at higher risk of hypertension, and Hispanics, who are at higher risk of diabetes.
- Improve education for children and young adults on the risks of tobacco, alcohol, and drug abuse, and the importance of diet and exercise.
- Increase the number of school nurses, so that they might participate in the teaching of health education classes.

Research

- Conduct research and evaluation to produce evidence-based strategies to learn what is most effective.
- Collect local data on heart disease and stroke (similar to cancer registry data).

Physical Activity

- Promote physical activity in the schools and the community.
- Develop after-school fitness programs for non-athletes and open schools for public use after school hours.
- Improve public access to areas such as sidewalks or bike paths and ensure public safety.

Healthcare Reform

- Expand the Healthy Families Program to include adults and emphasize primary care and prevention services.
- Mobilize all members of the healthcare system, including dentistry, optometry, ophthalmology, primary care, gynecology, to actively screen for risk factors for stroke and heart disease.
- Develop a regional approach to managing stroke and heart disease, directing patients to high volume centers with excellent outcomes and low complication rates.
- Fully integrate the emergency medical response (EMS) efforts into prevention activities and health management of communities.
- Offer tax breaks and other legislative incentives for healthful activities at workplaces (e.g., sports teams, healthful cafeteria menus, and exercise programs).

Nutrition

- Promote access to healthful foods, including fresh fruits and vegetables, in communities and in schools.
- Develop standardized food serving sizes.
- Support local efforts to improve access to quality nutritious foods, including farmer's markets and community garden projects.

Environment

- Encourage cities to line their streets with trees for their beauty and improved air quality.
- Encourage "Smart Growth" (the development of mixed-use neighborhoods that provide services, shopping, and other destinations within walking or bicycling distance of homes).

Question number 2: What do people in California need to learn about heart disease and stroke? What do physicians and other healthcare professionals need to learn about heart disease and stroke?

Panelists and community members identified the following topics regarding heart disease and stroke education. One recurring theme across the state was the need for improved education on the signs and symptoms of heart disease and stroke. Other topics that were discussed included:

Californians

- Cardiovascular disease is the leading cause of death in men AND women, and it is a preventable disease.
- Regular screenings for lipid levels and blood pressure are an important component of healthcare.
- Provide education about starting medical treatment within the first 60 minutes after a heart attack or stroke, e.g., the "Golden Hour".
- Parents' actions affect their children; the prevention of risk factors, including instilling good eating habits and adequate physical activity, starts in childhood (not once a disease is diagnosed).

Healthcare Professionals

- Collaboration must take place between different sectors (planning and development, business, etc.) to promote better community health, especially if we are to attain the Healthy People 2010 Objectives.
- Create and support data registries and include information on populations, outcomes, and risk factors in different communities.
- During routine clinical visits, integrate patient education on risk factor reduction, including diet, exercise, and smoking cessation.

Question number 3: What needs to happen in California schools, workplaces, and communities to prevent heart disease and stroke?

The responses from panelists and community members regarding changes in schools, workplaces, and communities, centered on improved nutrition and increased physical activity. The highlights from question 3 are as follows:

Schools

- Teach physical education and activity in all schools; give weight to their true value by having specific standards, adequate funding, and adequate time allocated during the school day for these activities.
- Enlist school boards to ensure that only nutritious foods are available in their schools and that physical education and health are part of the curriculum.
- Adequately fund schools so that they are not supporting themselves with revenues from unhealthy food and drink sources.
- Incorporate school gardens into the general curriculum, in conjunction with classes on healthy food preparation.
- Mandate that smaller schools, in close proximity to residential areas (not on edges of communities), be built so that walking to schools is a realistic option.

Workplaces

- Provide wellness programs and informational classes in the workplace, along with an environment that is conducive to supporting physical activity (e.g., (walking tracks around buildings, walking clubs, safe and inviting stairwells, showers, lockers, and childcare).

- Educate employers about the financial benefits of supporting wellness programs in the workplace.
- Make fruits, vegetables, and other healthy foods available in vending machines and in cafeterias.
- Create incentives for physical activity (such as health club discounts) and healthful eating.
- Promote flex-time options that allow time for fitness activities in the daily schedule.

Communities
- Develop and maintain a pedestrian-friendly, safe environment for cycling, skating, and walking.
- Ensure that supermarkets and farmers markets sell fresh fruit and vegetables in low-income communities.
- Increase access to cardiovascular resuscitation (CPR) training and defibrillators.
- Make educational materials in multiple languages available in various community locations such as the DMV, community centers, health clinics, etc.
- Create regional approaches to cardiovascular disease prevention and treatment and have community leaders form partnerships with public health professionals.
- Encourage health professionals to sit on land use planning boards. (Only 1 percent of planning boards across the nation have healthcare professionals.)

Question number 4: What needs to change in the healthcare setting to improve a) prevention of heart disease and stroke, and b) quality of treatment delivered to patients with heart disease or stroke?

Panelists and community members were emphatic about the need for increased education to prevent heart disease and stroke. Improvements in quality of care focused on regional approaches for treatment of acute heart disease and stroke events. Question 4 highlights are as follows:

Prevention
- Healthcare professionals need to work across sectors with community planners to increase the importance of designing healthy communities.
- Profile all patients' cardiovascular disease risk, regardless of their reason for seeing a provider.
- Establish and support reimbursement for prevention services.
- Provide educational handouts for patients, along with cardiovascular report cards.
- Make risk factor management classes available for healthcare professionals.

Quality of Treatment
- Implement treatment guidelines for diabetes, hypertension, and high cholesterol.
- Develop population registries, with built-in tracking and modeling based on evidence-based guidelines. Minimize the hospital/practitioner data collection burden to limit duplicate reporting to regulatory agencies.

- Implement a team approach for clinics treating heart disease and stroke follow-up, utilizing the expertise of dietitians, health educators, and nurses.
- Create incentive programs to better manage health outcomes.
- Identify best resources for emergency medical services dealing with heart attack and/or stroke victims.

Question number 5: How can we reduce health disparities in heart disease and stroke?

Representatives from underserved populations were present at each of the seven public forums. These individuals provided a first-hand account of the changes needed to achieve the goal of reducing the burden of heart disease and stroke in their communities. Highlights from question 5 included:

- Provide cultural competency training in treating and interacting with a variety of populations including people with developmental disabilities.
- Educate in a culturally specific manner about the importance of stroke and heart disease prevention as a part of school curricula and local community events and through community organizations.
- Ensure that those involved in developing healthcare strategies are from diverse communities. The input from a diverse group of community members (ethnic groups, women, elderly, etc.) is critical.
- Look at factors that support people in engaging in healthy behaviors and address these from a population-specific standpoint: housing, jobs, jobs with health insurance, pedestrian-friendly communities, and access to healthy foods.
- Educate the community on standards of care, patient rights, and questions to ask of their providers.
- Increase the opportunities to involve people from different populations in clinical trials.
- Develop educational materials that are culturally, language- and reading-level appropriate.

CONCLUSION

The public forums were held for the primary purpose of providing the Heart Disease and Stroke Prevention and Treatment Task Force with input from various regional stakeholders on heart disease and stroke in California. This public forum report, a compilation of the public forum input, will be one of the important reports presented to the newly convened Task Force. The public forums were a means to publicize the seriousness of heart disease and stroke in California. This report does not attempt to present a consensus statement; rather this report reflects the voices of the people of California.

Eureka Public Forum on Heart Disease and Stroke Prevention and Treatment

Summary of Key Findings

Panelists and community members highlighted the magnitude of problems related to heart disease and stroke in Eureka and throughout the state of California and offered specific strategies to address these problems. This summary captures the key points presented by expert panelists and community members at the public forum held on April 6, 2004.

Specific Findings and Recommendations

QUESTION #1:
WHAT ARE THE THREE MOST IMPORTANT CHANGES IN CALIFORNIA THAT NEED TO BE MADE IN ORDER TO REDUCE DEATH AND DISABILITY FROM HEART DISEASE AND STROKE?

- A community-based public awareness program to educate about the early signs and symptoms of heart attack and stroke.
- Fitness levels must change for the better, beginning in childhood.
- We tend to "atomize" the mind-body-spirit and address them separately when they are, in fact, all part of one entity. If folks are busy trying to survive, telling them to "eat better and exercise" is a futile endeavor and likely counterproductive, since it may add to shame, guilt, etc. Furthermore, barriers to change include other social and cultural differences that need to be acknowledged and addressed.
- Approach this problem from a public health perspective. Prevent the very risk factors (hypertension, abnormal cholesterol levels, abnormal body mass index, etc.) that lead to chronic illnesses like diabetes, and ultimately, to heart disease and stroke.
- Prevention, prevention, prevention. We talk a lot about prevention but we don't fund it. Put serious money into prevention. Inadequate funding is one of the weaknesses in our state and nation.
- Create a universal healthcare system and support SB 921 (Kuehl); this legislation would go a long way towards getting universal healthcare.
- Implement classroom programs, such as the American Heart Association's "Heart Power". Teachers won't pick up these curricula on their own; to be successful, someone needs to model this program for them. Use tobacco money for this program.

QUESTION #2:
WHAT DO PEOPLE IN CALIFORNIA NEED TO LEARN ABOUT HEART DISEASE AND STOKE? WHAT DO PHYSICIANS AND HEALTHCARE PROFESSIONALS NEED TO LEARN ABOUT HEART DISEASE AND STROKE?

Californians

- Make people aware of the fact that certain drug treatments for vascular patients are essential and that precise management of predisposed illnesses (hypertension, diabetes), as well as lifestyle modifications, are also essential.
- Inform folks that the lifestyle changes need to be started in childhood, not once a "disease" is diagnosed.
- Work with parents to change unhealthy behaviors in kids.
- People need to understand what having "risk factors" means. If people are not privy to the language, we won't have any impact.

Healthcare Professionals

- Healthcare providers mush be aware of standards of care and evidence-based guidelines and institute these when seeing patients.
- Physicians need to change their own behavior by following their own recommendations and living a healthier lifestyle.
- Providers need to institute healthcare management programs that incorporate the expertise of health educators, dieticians, providers, specialists, etc. to educate and treat patients; the "lone physician" can no longer be the paradigm for adequate patient care.

QUESTION #3:
WHAT NEEDS TO HAPPEN IN CALIFORNIA SCHOOLS, WORKPLACES, AND COMMUNITIES TO PREVENT HEART DISEASE AND STROKE?

Schools

- Adequately fund schools so they are not supporting themselves with revenues from unhealthy foods and beverages. It doesn't make sense to tell children to eat healthy foods and then ask them to sell candy bars to raise money for the school.
- Schools need to focus on providing and teaching about healthy foods and physical activity.
- Bring back school nurses.
- Stop using sweet incentives in schools. On Valentine's Day and holidays it is sort of expected, but maybe this could be changed into a cooking day in the classroom to learn about good food choices and their preparation.
- School districts need to get physical education back in the schools.
- Teach health classes.

Workplaces

- Make work breaks and the worksite conducive to physical activity and give it genuine value.
- Promote wellness by providing educational information with paychecks and give employees tangible incentives for practicing healthier behaviors.
- Slow elevators down to encourage the use of stairs.
- Only provide healthy foods at meetings and conferences.

Communities

- Involve the community by asking its members what they think needs to be done. This gives them ownership of the solution.
- Promote community gardens and provide space and assistance for those who want to start community gardens.
- We have created pedestrian-free cities and spaces. There is a stigma to walking and bicycling but there are a host of things we can do to improve a community's landscape to make it easier for people to walk and bicycle.
- Through community-based organizations we can support healthy eating at meetings and sports events.
- Assist mom-and-pop stores to make healthy food choices available. They are often the first place that kids shop in after school.

QUESTION #4:
WHAT NEEDS TO CHANGE IN THE HEALTHCARE SETTING TO IMPROVE: A) PREVENTION OF HEART DISEASE AND STOKE, AND B) QUALITY OF TREATMENT DELIVERED TO PATIENTS WITH HEART DISEASE OR STROKE?

Prevention

- To emphasize and elicit interest in disease prevention, financial incentives must be reestablished for healthcare providers.
- Improve the healthcare system by focusing financial support on prevention services.
- We should develop partnerships with community leaders working toward a solution that works and gains their buy-in. We often leave the community, community leaders, and patients out of the program planning equation.
- Mentoring: individual mentoring and media-based approaches work the best to get people walking, biking, and using public transit.
- Teach people that each moment during a heart or stroke event counts. Provide more education about the early signs and symptoms of heat disease and stroke.
- Give the public information about the different risk factors of stroke, including sleep apnea.
- Improve post-hospital discharge and how seniors are taken care of at home to prevent subsequent heart disease and stroke events.
- AHA launched a "Go Red for Women" campaign to educate women about the signs and symptoms of heart disease. This campaign will also educate physicians about new protocols for diagnosing and treating heart disease in women.

Quality of Treatment

- Understand treatment guidelines for diabetes, hypertension, and cholesterol.
- Acknowledge social and cultural issues and act in a partnership arrangement with our patients based on what is learned from them.

QUESTION #5:
HOW CAN WE REDUCE HEALTH DISPARITIES IN HEART DISEASE AND STROKE?

- Switch our thinking to what makes people healthy and unhealthy: jobs, housing, jobs with health insurance, walkable communities, and access to healthy foods. We don't live in a vacuum.
- There is a difference between how men and women are treated as cardiac patients. There is also a difference between men and women in the kind of follow-up care and testing they receive.

Eureka Heart Disease and Stroke Prevention Public Forum:
Tables with Panelists' and Public Comments

April 6, 2004, Humboldt Area Foundation Community Center, 373 Indianola Road, Bayside, CA 95524

Panelists:

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Ann Lindsay, MD
Health Officer
Humboldt County Department of Public Health, Health and Human Services

Mary Anne McCrea, RN, MS, ACHE
Vice President/Chief Operating Officer
St. Joseph Hospital

Terry Raymer, MD, CDE
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- Belma Gonzalez, Program Coordinator, Center for Collaborative Planning.
- Heather Hutcheson, Program Coordinator, Center for Collaborative Planning.
- Connie Chan Robison, Director, Center for Collaborative Planning.

Number Attending:
19 Audience Members
8 Panelists

Promotional Activities:
The Planning Committee for the forum forwarded the Save-the-Date flyer to local stakeholders. The Center for Collaborative Planning (CCP) sent press releases and Save-the-Date information to state representatives and county supervisors and the American Heart Association. In addition, CCP sent press releases to local media outlets, including print, radio, and TV through Congress.org. Outlets reached include:

- USA Today
- KEET (PBS 13)
- KIEM (NBC-3)
- KVIQ (CBS-6)
- Daily Triplicate
- Times-Standard
- KAEF (ABC-23)
- KBVU (Fox 29)
- KHSU 90.5 FM (Humboldt State University) (NPR)

1. What are the three most important changes in California that need to be made in order to reduce death and disability from heart disease and stroke?

Panelist	Most Important Changes to be Made
Mary Anne McCrea, RN, MS, ACHE, Vice President/Chief Operating Officer, St. Joseph Hospital [written comments]	• Establish community-based awareness programs to teach people (patients) signs and symptoms of impending compromise of the vasculature of the heart and brain. Explain what symptoms mean. Patients with the disease will then be identified earlier and thus appropriate treatment will be instituted to avoid end-organ damage. • Identify specialized centers for the treatment of vascular disease. Those should be highlighted by means of public relations efforts. (Earlier referral). • Specialized and goal-oriented follow-up program must be established at those centers. (Patients who are sent home should be given specific instructions for follow up). • We need to follow-up patients with heart and stroke diseases that created their current health crisis and subsequent episodes to prevent disability. [verbal comment] • To prevent death and disability there should be education through a community-based public awareness program. People should be educated regarding the early signs and symptoms of heart attack and stroke.
Terry Raymer, MD, CDE Diabetes Program Director, United Indian Health Services, Area Diabetes Consultant [written notes]	• Fitness levels must change starting in childhood. • Significant changes in the content and amounts of food must start during infancy. This includes issues like breastfeeding promotion. • Address life circumstances that increase stress, depression, and anxiety, resulting in deleterious fitness levels and unhealthy eating habits. This includes socioeconomic factors such as poverty, lack of education, food insecurity, and abuse. • People are generally aware that healthier eating habits and physical activity are beneficial. What people need is a reason to change their behavior. • We tend to “atomize” the mind-body-spirit and address them separately when they are in fact all part of one entity. If folks are busy trying to survive, telling them to “eat better and exercise” is a futile endeavor

Panelist	Most Important Changes to be Made
Terry Raymer, MD, CDE (cont'd)	and likely counterproductive, since it may add to shame, guilt, etc. Furthermore, barriers to change include other social and cultural differences that need to be acknowledged and addressed. • I would recommend that every medical student be required to read Anne Fadiman's book, *The Spirit Catches You and You Fall Down*. • Smoking cessation is crucial, but we also need to address some of the reasons why people start smoking and address those issues. For instance, studies show that women who smoke more often are victims of abuse in their past. • This is only one example of how we can't just address the smoking problem, but must address other issues that cause the problem in the first place. These issues may seem remote to heart disease and stroke, but I would submit they are crucial to long-term goals toward true prevention. It may be more characteristic for a physician to say we need to better treat hypertension, cholesterol, and diabetes (or the "metabolic syndrome") to prevent cardiovascular disease and while this is quite true, these are late (possibly too late) stages of prevention. • We need to have a public health approach to this problem because it is a public health problem. In keeping with this approach, we should be preventing the very risk factors (hypertension, abnormal cholesterol levels, abnormal body mass index, etc.) that lead to chronic illnesses like diabetes, and ultimately to heart disease and stroke.
Peggy E. Falk, MPH Manager, Health Education Division, Humboldt County Department of Public Health and Human Services	• Prevention, prevention, prevention. We talk a lot about prevention, but we do not fund it. We need to put serious money into prevention. Inadequate funding is one of the weaknesses in our state and nation. • We need to fund long-term research for evidence-based strategies. • We need to build in quality program evaluation to make sure a given strategy is effective. • We need to address smoking and tobacco use at every opportunity. Too many adults and kids are using tobacco. We are not taking this issue seriously enough. We need to stop driving by schools where we see kids smoking if we are doing nothing about it.

Panelist	Most Important Changes to be Made
Ann Lindsay, MD Health Officer Humboldt County Department of Public Health and Human Services	• Less than one-percent of the public health departments in the state have prevention programs. • There is a split in the healthcare system between curative medicine and preventive medicine. Many people don't have access to either. We need a universal healthcare system. • We need to support SB 921 (Kuehl). This legislation would go a long way towards getting universal healthcare. • SB 101 (Chesbro) should be supported to create parity treatment for substance abuse services, including tobacco use. There is only minimal coverage of tobacco cessation programs because insurance companies have a shorter-term view and don't pay for cessation programs and medicine.
Joyce M. Houston, RD Public Health Nutritionist Humboldt County Department of Public Health, Health and Human Services	• We need financial and community support to prevent overweight. There should be incentives and programs in schools, workplaces, meetings, etc. • On a state level, we should market a healthy eating campaign. We need money for an evidence-based, healthy eating, and physical activity campaign.
Cheryl Hale, LVN Tobacco Use Prevention Education (TUPE)/Community Outreach Technician Humboldt County Office of Education	• There are good programs for the classroom but they are not being implemented. We should use "Heart Power!" Program, an AHA strategy, in the classroom. Teachers won't pick up these curricula on their own. To be successful, they need someone to model this program. We should use tobacco money for this.

Public Comments on Question #1: None

2. What do people in California need to learn about heart disease and stroke? What do physicians and healthcare professionals need to learn about heart disease and stroke?

Panelist	Californians	Healthcare Professionals
Mary Anne McCrea, RN, MS, ACHE, Vice President/Chief	• People need to be made aware of the fact that certain drug treatments for vascular patients are essential, and precise management of predisposed illnesses	• Physicians need to be made aware of the fact that certain drug treatments for vascular patients are essential, and precise management of

Panelist	Californians	Healthcare Professionals
Mary Ann McCrea, RN, MS, ACHE (cont'd) [written notes]	(hypertension, diabetes) as well as lifestyle modification are also essential.	predisposed illnesses (hypertension, diabetes) as well as lifestyle modification are essential. • This treatment program should, in essence, follow the secondary prevention program as published and advocated by the American Heart Association.
Terry Raymer, MD, CDE Diabetes Program Director, United Indian Health Services, Area Diabetes Consultant [written notes]	• People first need to know these diseases are all inter-related, particularly conditions like the "metabolic syndrome": diabetes, hypertension, cardiovascular disease, and stroke. • They then need to know that, to some degree, these conditions are preventable. • We need to inform folks that the changes need to be started in childhood, and not once a "disease" is diagnosed. As an example: a patient may think he or she does not need to change the way they eat until they have been diagnosed with high cholesterol, diabetes, or coronary artery disease. "Oh! Now I have to eat differently than my friends and family!" No, the change needed to start long before, during childhood, and we all	• Healthcare providers need to know all of the information stated under "People In California" and convey it to our communities. We need to find out from our patients and community members how best to do this. • We also need to change our own behavior. We need to follow our own recommendations for a healthier lifestyle. • We also need to change the mindset that patients are "non-compliant" when they do not immediately change their behavior or follow our advice. Human beings make changes based on a whole host of factors and we need to explore these issues to help facilitate behavioral change. • On the more "medical" side, healthcare providers need to be aware of standards of

Panelist	Californians	Healthcare Professionals
Terry Raymer, MD, CDE (cont'd)	need to be doing it. • It is similar to the effort to get people to stop smoking. The good news is that the heart and stroke prevention measures are similar. There isn't a separate set of recommendations for each condition. [verbal comments] • Patients need to understand that so many disease conditions are interrelated, for example, diabetes can lead to heart disease and stroke. • People will say, "We should start cooking differently for mom now that she has diabetes." But healthy ways of eating should be followed before someone is ill. • People start smoking for a reason and we have to address the reasons. • Patients and kids who take up a new physical activity should have mentors. Fathers or grandfathers are needed to encourage kids and to talk about the best way of doing something.	care and evidence-based guidelines and institute these when seeing patients. • We must test for abnormal lipid levels, blood pressure, blood sugar, and other risk factors (screening or case-finding when appropriate) and then treat these factors to target a certain level that the patient should strive to reach (e.g., if an LDL cholesterol goal for a diabetes patient is 100mg/dl, we must attain or exceed this target). • We also must institute healthcare management programs that incorporate the expertise of health educators, dieticians, providers, specialists, etc. to educate and treat patients; the "lone physician" can no longer be the paradigm for adequate patient care.
Ann Lindsay, MD Health Officer Humboldt County Department of Public Health and Human Services	• We should work with parents to change unhealthy behaviors in kids. • We should educate people about instilling good eating habits in	• If doctors talk to their patients about tobacco, exercise, and eating habits, it is likely that it will have a positive impact.

Panelist	Californians	Healthcare Professionals
Ann Lindsay, MD (cont'd)	good eating habits in their children and the effect that good nutrition can have on their health. Youth are our salvation.	• People may not always change as much as we want. • We need to work as a team to approach issues in the clinical setting. • Clinical practice guidelines on how to identify and manage signs and symptoms of diseases should be utilized. We need to systematically integrate the guidelines into everyday practice.
Joyce M. Houston, RD Public Health Nutritionist Humboldt County Department of Public Health, Health and Human Services	• Young women will smoke to control their weight and once they start, it is hard to quit. And then, when they are able to quit smoking, then they may gain weight. • Major chronic conditions and diseases are linked (for example: overweight and decreased activity). • People need to understand what having "risk factors" means. If people are not privy to the language, we won't have any impact. • The public needs to know the genetic links between diseases. Because a family member had a disease or is overweight, it doesn't mean they will automatically have to be overweight or have the same illnesses.	

Panelist	Californians	Healthcare Professionals
Joyce M. Houston, RD (cont'd)	• Marketing of prevention efforts and their potential impact needs to happen. • Parents need to know that their actions and their inability to take actions may affect their children. • We need to support the families who adopt and maintain healthy lifestyles. • What a woman eats during pregnancy and breast-feeding may affect the types of food the child will eat later in life. • Families need to be taught how easy it is to prepare healthy meals. • Having family meals together is the key to promoting a healthy lifestyle. • Up to this point, increasing the consumption of vegetables and fruits has been the focus. Now, we need to go beyond this and look at whole grains and also at decreasing fat and dairy products.	
James P. Gambin, MD Humboldt Neurological Medical Group	• People need to eat well, exercise, and be able to identify risk factors for heart disease and stroke.	

Public Comments on Question #2: None

3. What needs to happen in California schools, workplaces, and communities to prevent heart disease and stroke?

3a. What needs to happen in California SCHOOLS to prevent heart disease and stroke?

Panelist	Schools
Mary Anne McCrea, RN, MS, ACHE, Vice President/Chief Operating Officer, St. Joseph Hospital [written notes]	• Physical exercise and dietary counseling is essential to avoiding obesity in the young. • Counseling that involves the parents is essential.
Terry Raymer, MD, CDE Diabetes Program Director, United Indian Health Services, Area Diabetes Consultant [written notes]	• We need to adequately fund schools so they are not supporting themselves with revenues from unhealthy food and drink sources. • Schools need to focus on providing, and teaching about, healthy foods and physical activity. • We need to give physical education its true value and show this by providing enough time during the school day, as well as by providing adequate funding. • Children need physical activity. It is as important as math, science, and reading.
Peggy E. Falk, MPH Manager, Health Education Division, Humboldt County Department of Public Health and Human Services	• Schools could adopt CDC guidelines regarding tobacco. • We need to get physical education back in the schools. • We can use (Project LEAN) as a nutritional policy.
Jennifer Rice Natural Resources Projects Coordinator Redwood Community Action Agency	• Walking and bicycling to school should be made safer.
Cheryl Hale, LVN Tobacco Use Prevention Education (TUPE)/Community Outreach Technician Humboldt County Office of Education	• Bring back school nurses. • School lunches should have nutritional standards. One school may be serving healthy meals while another is serving Taco Bell burritos and they are both spending the same amount of money. • Some kids' choices are limited by the free breakfast and lunch programs they are enrolled in. • Not a lot of attention is paid to the nutritional value of school food, but at least vending machines are vanishing from campuses.

Panelist	Schools
Cheryl Hale, LVN (cont'd)	• There need to be physical education standards. Sometimes when a school asks me to come in and give a presentation on a health-related issue, they give me the time slot that is usually scheduled for physical education. This takes the kids away from their physical activity. The schools combine health and physical education and they shouldn't because each one takes time away from the other. • Schools could use a lot of teen leaders to help with the younger kids. • We need to stop using sweet incentives in schools. On Valentine's Day and holidays, it is sort of expected, but maybe this could be changed into a cooking day in the classroom to learn about good food choices and preparation.
Joyce M. Houston, RD Public Health Nutritionist, Humboldt County Department of Public Health, Health and Human Services	• We need a comprehensive approach about what to teach in the classroom. • It doesn't make sense to tell children to eat healthy foods, and then ask them to sell candy bars to raise money for the school. • School meal quality should be addressed. There are so many pre-packaged fast foods. We need to work on getting pre-packaged foods a little healthier. • Kids should be taught healthy food preparation. If kids are learning healthy food preparation at school they will talk about it at home and do it for their families.
James P. Gambin, MD Humboldt Neurological Medical Group	• Stress physical activity with kids and encourage teachers to be the role models. • Remove vending machines from schools.

Public Comments on Question #3a:

Community Member	Schools
Ruth Fairfield School Nurse Humboldt County Office of Education	• We have many small school districts. We need to go to the school boards and ensure there are no soda machines on campuses and that nutritious lunches are served. • Smaller schools should be ordering from larger school districts and having lunches shipped over. • We should stress that school districts get physical education back in the schools. • There should be a state master plan for physical education including teaching skills for games. If we teach kids activities like games, they will do them for

Community Member	Schools
Ruth Fairfield (cont'd)	life. Then the school districts will need to follow the state plan. • Health classes need to be taught. Children should get information about smoking, alcohol, and drugs every year. • In primary school, and even pre-school, we need to get the parents involved. • Quitting smoking is the hardest thing a person can do: on average it takes nine attempts to quit.
Jamie Morgan Legislative Director American Heart Association	• With regard to physical activity in the schools, school boards and the superintendent make the decisions. • Physical education and nutrition need to be included in the curriculum.
Lin Glen Project Director Tobacco Education Program	• For every $1 spent, effective tobacco cessation programs in the schools can save $19.00 in healthcare costs.

3b. What needs to happen in California WORKPLACES to prevent heart disease and stroke?

Panelist	Workplaces
Terry Raymer, MD, CDE Diabetes Program Director, United Indian Health Services, Area Diabetes Consultant	• Make work breaks and the environment conducive to physical activity and give it genuine value. • Some companies have modeled this successfully both here and abroad. • Make workplaces accessible to "alternative transportation" options by providing showers/lockers and bike racks. • Promote wellness by providing educational information with paychecks (again this has been modeled) and give employees tangible incentives for those who practice healthier behaviors. • Providing childcare and other support will also relieve workers from burdens that keep folks away from physical activity and other healthy behaviors.
Peggy E. Falk, MPH Manager, Health Education Division, Humboldt County Department of Public	• A healthy workforce is part of the employers' responsibility and they need to know that it affects their bottom line. • Elevators should be slowed down to encourage walking up the stairs.

Panelist	Workplaces
Health and Human Services	• Only healthy foods should be available at meetings and conferences.
Jennifer Rice Natural Resources Projects Coordinator Redwood Community Action Agency	• In workplaces, there should be incentives for walking or bicycling to work. Showers should be made available. • The more active a workforce is, the more productive they may be at work.

Public Comments on Question #3b: None

3c. What needs to happen in California COMMUNITIES to prevent heart disease and stroke

Panelist	Communities
Terry Raymer, MD, CDE Diabetes Program Director, United Indian Health Services, Area Diabetes Consultant, [written notes]	• We should involve the community members by asking them what needs to be done. This gives them ownership of the solution. • Socioeconomic changes would help most. Primarily, the more we invest in preventing poverty, lack of education, and abuse, the better we will be able to get folks out of the "survival" mode and into the "prevention" mode. Why would you want to bother preventing a heart attack if your life is filled with despair? • Design communities that are not car friendly but "people-powered-transport" friendly. Many communities do not feel like safe places to bike and walk. • Stop subsidizing nutritionally bankrupt foods. • Promote community gardens and provide space and assistance for those who want to start community gardens.
Peggy E. Falk, MPH Manager, Health Education Division, Humboldt County Department of Public Health and Human Services	• Our most important resource here, in Eureka, are our people. When we lose someone it affects the entire fabric of the community. • We need to look at the individual and why they choose to eat junk foods. We need to see the bigger picture and see how individual choices like this affect the whole community. • There should be comprehensive tobacco laws, we need to enforce existing tobacco laws, and we need to prevent tobacco advertising to kids. • We need to make communities more walkable.

Panelist	Communities
Jennifer Rice Natural Resources Projects Coordinator Redwood Community Action Agency	• We have created pedestrian-free cities and spaces. There is a stigma to walking and bicycling. But there are a host of things we can do to improve a community's landscape to make it easier for people to walk and bicycle. • We have engineered ourselves out of physical activity. We need to break down barriers to physical activity. • We need to do research to identify reasons people aren't walking. Is it because of safety issues? inconvenience? comfort? • There is research to show money is thrown out the window when we don't invest in prevention of diseases. • There are tools to break down barriers and we need to get them into the hands of people who can utilize them. • We need to design guidelines for walkable communities. We should conduct a pedestrian needs assessment. • We should provide and incentivize tools for engineers and city planners. • Our communities are based on cars. We need to build communities that encourage walking and biking that are inviting and rewarding for pedestrians and bicyclists.
Joyce M. Houston, RD Public Health Nutritionist, Humboldt County Department of Public Health, Health and Human Services	• Through community-based organizations we can support healthy eating at meetings and sports events such as soccer games. • We need to teach people about healthy food preparation. • We need to assist mom and pop stores to make healthy food choices available. They are often the first place children stop after school.
James P. Gambin, MD Humboldt Neurological Medical Group	• People need to have the ability to walk and ride bikes. They need to be able to get out of their chairs, away from the TV, and walk safely.

Public Comment on Question #3c:

Community Member	Communities
Lin Glen Tobacco Project Director County of Humboldt Dept. of Public Health	• The medical community needs to look at tobacco use as a chronic disease and address it every time they see a patient.

4. What needs to change in the healthcare setting to improve a) prevention of heart disease and stroke, and b) quality of treatment delivered to patients with heart disease or stroke?

Panelist	Prevention	Quality of Treatment
Mary Anne McCrea, RN, MS, ACHE, Vice President/Chief Operating Officer, St. Joseph Hospital [written comments]	• To emphasize and elicit interest in disease prevention, financial incentives must be reestablished for healthcare providers. • As Dr. Michael DeBakey said during subcommittee hearings in Washington, DC, with a decrease in money for healthcare providers, "you get what you pay for." • A general effort must be made for the people in California to understand that healthcare is an essential commodity. • With the current low reimbursement rate, the best and brightest no longer enter the field of cardiovascular medicine. [verbal comments] • Where are the incentives for healthcare? We are treating the end result. The crisis or the episode that is what the reimbursement is for. There is no incentive	[verbal comments] • In healthcare, we follow the money; we're really not in the business of health and healthcare. • If we are looking at treating cardiovascular disease, there are certain drugs that can be prescribed, but these tend to be the most expensive drugs. Most people don't use these prescriptions because they are so expensive.

Panelist	Prevention	Quality of Treatment
Mary Anne McCrea, RN, MS, ACHE (cont'd)	for preventive care. • As a healthcare professional, I enjoy treating the whole patient. But if we look at the reimbursement structure, we are not treating the whole patient. • It is hard, if not impossible, to get reimbursements for dietary counseling, smoking cessation, the socioeconomic reasons for obesity, lack of physical activity, etc. • When we follow the money, the money supports the end results, treatments such as surgery. • To improve the healthcare system, we need to focus our financial support on prevention and lifestyle changes.	
Terry Raymer, MD, CDE Diabetes Program Director, United Indian Health Services, Area Diabetes Consultant [written notes]	• Healthcare providers need to shift the way they view these issues. • We also need to discuss primary and "primordial" prevention measures with the families and communities we care for to allow folks to understand preventive action is needed before diabetes,	• We need to have an understanding of and be able to follow treatment guidelines for diabetes, hypertension, and cholesterol. • We must acknowledge social and cultural issues and act in a partnership arrangement with our patients based on what we learn from them. • We must talk to patients about what these illnesses mean to them and what

Panelist	Prevention	Quality of Treatment
Terry Raymer, MD, CDE (cont'd)	diabetes, hypertension, heart attack, and high cholesterol show up. • A public health approach is required to accomplish this. [verbal comments] • We need to work on measures with the family and with the community. People understand genetics and their role in disease. • We need to do primary and secondary prevention. • We need to set up institutions for primary prevention. We need to identify risk factors and metabolic symptoms. We shouldn't wait for diabetes to develop or the first heart attack to occur. • We should develop partnerships with community leaders working toward a solution that works and gains their buy-in. We often leave the community, community leaders, and patients out of the program planning equation. • Discussion with patients takes time. We need to negotiate	mean to them and what their perception and interest is in making changes. For example, simply giving someone who has had a heart attack a "prescription" for either exercise or a statin may result in just a piece of paper thrown in the trash. We need to learn their specific social, economic, and cultural issues and how best to approach the patient with that knowledge. • We can negotiate behavioral changes and beneficial treatments based on the patient's understanding, not our own! • The healthcare system must integrate various providers and educators. • I would take a statin because I know all the details, but if our patient gets a prescription for this and then hears some report from the media that statins can cause liver problems, we all know what will happen. This is only an example, but on every level this has to be a *partnership* with the patient, not something "being done" to them; otherwise we will fail. • Additionally, we need more time with patients and to value the time spent with them. [verbal comments] • We need treatment guidelines for diabetes and

Panelist	Prevention	Quality of Treatment
Terry Raymer, MD, CDE (cont'd)	change in the healthcare system so we have more time to understand where the patient is coming from. • On all levels, we need partnerships or we will fail.	hypertension.
Ann Lindsay, MD, Health Officer Humboldt County Department of Public Health and Human Services		• The important commodity of the healthcare system is money, not health. Managed care improved this imbalance somewhat. We need to reorganize the healthcare system and make health the main goal. • People need to be paid a salary and make healthcare available to everyone. • The diabetic project in our community is a good model. We created a system of care with all aspects of health addressed. We work as a team and there is a registry with prompts and reminders for patients. We will be able to look at objective measurements of diabetic control in our community and outcomes will improve. It took securing funding and having the providers put in extra effort.
Jennifer Rice Natural Resources Projects Coordinator Redwood Community Action Agency	• Things are starting to change. The "Active Living Network" increased the number of groups facilitating dialogue and action collaborative efforts.	

Panelist	Prevention	Quality of Treatment
Jennifer Rice (cont'd)	• If the health community can provide research to community planners, most planners want to do what is best, especially if they hear it from various sectors. • A study conducted shows that in a walking friendly neighborhood, thirty-five percent of the residents were overweight. Sixty-five percent were overweight in non-walking friendly neighborhoods. • Individual mentoring and media-based approaches work the best to get people walking, biking, and using public transit. • The health community needs to be involved in land use issues because it affects daily activity levels. Sidewalk obstacles need to be removed. • The community is being built out of walking. We should demand changes and it will help if the health community can wrap its arms around planning concepts.	

Panelist	Prevention	Quality of Treatment
James P. Gambin, MD Humboldt Neurological Medical Group	• Increase the ability for people to have memberships in health clubs. • People need to learn that each moment during a heart or stroke event counts. We need to provide more education for early signs and symptoms of heart disease and stroke. • We need to get information to the public about the different risk factors of stroke, including sleep apnea. We need to increase public awareness and follow through.	• St. Joseph's Hospital is buying a new MRI machine to determine if a person is having a transient ischemic attack (TIA) and this is important because a proper diagnosis can prevent the loss of brain tissue. We can determine if the patient is having a TIA in the emergency room and make a faster diagnosis.

Public Comments on Question #4:

Community Member	Prevention	Quality of Treatment
Sylvia Jutile Community Advocate American Cancer Society Volunteer	• Tobacco use is right up there in importance, even though we now most of the talk is about obesity. Tobacco use is still a very serious problem in bars. The number one reason people begin smoking again is that they are having a drink and then they smoke. • We need to be more vigilant about places that sell cigarettes to minors. • Smoking cessation programs reach the upper middle class, not	

Community Member	Prevention	Quality of Treatment
Sylvia Jutile (cont'd)	upper middle class, not the poor. • Smoking cessation media efforts have a real impact but it is expensive. We should promote TV advertising for cessation programs and incentivize cessation programs. Food banks could also advertise. People could be encouraged to go to the library for half an hour to do the "I QUIT" program and then they could receive an award. • We need to stop tobacco internet sales. • There are culturally appropriate smoking cessation programs for Native Americans. • The American Cancer Society will conduct free smoking cessation programs, including work site programs.	
Sandi Fitzpatrick Executive Director Area 1 Agency on Aging	• We need to design communities for the older adult population. This will create a shift back to getting people moving and active. • Twenty-percent of our community is elderly. This is higher than other areas in California. The ability to afford medicines is a big concern, too. • We need to look at post-hospital discharge and how seniors are	

Community Member	Prevention	Quality of Treatment
Sandi Fitzpatrick (cont'd)	and how seniors are being taken care of at home so that subsequent heart disease and stroke events can be prevented. • Our community has been lucky in getting state grants for the "No More Falls" and "Sit and Fit" programs. However, these programs will be ending soon. We also have a Coke grant, which involves a task force that includes an RD, MD, RN, etc. We also have a strength-training program for older adults. We increased the number of males in the classes. This program aims to promote fall prevention in older males. • We need a "Walkability Workshop." If we have a safe walking environment for kids, it will also be safe for older adults. • A big concern is that there is inadequate and unaffordable healthcare. • As we live longer, disease prevention is key.	
Jamie Morgan Legislative Director American Heart Association	• With regard to education on heart disease for women, AHA launched a	

Community Member	Prevention	Quality of Treatment
	program called "Go Red for Women." It educates women to recognize signs of heart disease. The focus is on educating women and doctors with new protocols. • We need to provide information regarding tobacco control, physical activity, and prevention. • We need legislation to prevent the tobacco internet sales. • When pushing legislation, we need to provide expertise to the legislators who are sponsoring the bills.	
Terry Raymer, MD, CDE, Diabetes Program Director, United Indian Health Services (speaking on behalf of Dr. Gambin)	• Sleep apnea can raise the risk factors leading cardiovascular disease and stroke.	
Lin Glen Project Director, Tobacco Education Program, Department of Public Health	• Tobacco-free Humboldt: $3.62 has been saved for every $1.00 spent on healthcare program. We used the media, increased price of tobacco, and changed policies in community agencies such as the public health department. • We need to enforce tobacco laws.	

Community Member	Prevention	Quality of Treatment
Trey Scott Executive Director CampFire USA Northern California Council	• Regarding tobacco cessation with youth, we need to focus on 18-24 year olds. We need to go where they go socially (including festivals so we can, promote smoke-free festivals). Use the media--TV, radio, and print. • We need a public relations/marketing piece and a "sharing of the mind." We need to learn from the advertising agencies on Madison Avenue. We need to have a community presence on as many fronts as possible. • We all sit in various circles and boards. We should network and share the work we are doing in our various circles with each other. We are very interdependent with one another. • We need to learn about things that are working in other areas of the state. It would be very valuable to learn information from the other forums. (Jeanne Emmick stated: We will send the site-specific reports and we will communicate with all of you. The Task Force will	

Community Member	Prevention	Quality of Treatment
Trey Scott (cont'd)	communicate with all of you and you will need to be the ones to implement the Task Force's plan).	

5. How can we reduce health disparities in heart disease and stroke?

Panelist	Opportunities to Reduce Disparities
Terry Raymer, MD, CDE Diabetes Program Director, United Indian Health Services, Area Diabetes Consultant [written notes]	• As long as there is a socioeconomic abyss in our society, there will remain health disparities. • It takes more time to work with patients who do not fit a sophisticated (educated) patient model. • Health reimbursement "specialists" give us pockets of time to see a patient for a particular issue, but to do what I have outlined above takes time and money. • We can pay now, or we can pay later. We may give lip service to all wonderful notions of addressing cultural and social issues, but until we are ready to spend the effort and money needed to do it (and it will take more effort than money), the problems will only get worse. • There will also need to be a public health effort directed both at communities and the state-at-large. • To combat heart disease and stroke, we can use similar models used by smoking prevention and cessation programs. • We will need to involve community clinics and community members to find out what is needed from them. This effort cannot be wholly directed from the outside. • We can come in with information, but to know how to translate and disseminate the information we must get community members' and leaders' input.
Peggy E. Falk, MPH Manager, Health Education Division, Humboldt County Department of Public Health	• This is a lot bigger issue than just heart disease and stroke. • We need to switch our thinking to what makes people healthy: housing, jobs, jobs with health insurance, walkable communities, and access to healthy foods. We don't live in a vacuum. • To make a difference in health disparities we need to look at the whole community. A poor community has more access to tobacco, is more likely to be unwalkable and unsafe.

Panelist	Opportunities to Reduce Disparities
Jennifer Rice Natural Resources Projects Coordinator Redwood Community Action Agency	• Look at the web site: www.cbsm.com. It is about community-based social marketing. It helps with identifying attitude changes. It recycles tools and techniques on how to change people's behaviors with a focus on different communities such as low-income communities. There are different ways to target communities incrementally, taking small steps so each community knows what it needs to do and then we need to provide them with the appropriate tools and information. • We created "Humboldt Bay Active Living" and RCAA as a model. We sent out e-mail invitations and the goal is to put physical activity back into daily life.

Public Comments on Question #5: None

Panelists' Open Microphone Comments

Panelist	Comments
Cheryl Hale, LVN Tobacco Use Prevention Education (TUPE)/Community Outreach Technician Humboldt County Office	• There is a difference between how men and women are treated as cardiac patients. There is also a difference in follow-up care and testing. This is because men and women may present with different symptoms. • Healthcare professionals don't think of women when they think of heart disease, even though heart disease is the number one killer of women.
Terry Raymer, MD, CDE Diabetes Program Director, United Indian Health Services, Area Diabetes Consultant	• Diabetic women lose the protection of their gender even before menopause. • We have to become attuned to the symptoms women with heart disease experience. • Women die more frequently from their first heart attack than men.
Jennifer Rice Natural Resources Projects Coordinator Redwood Community Action Agency	• More women than men are the caregivers for others. We need tools to fit into busy family schedules. • In the Eureka area there is a website which details bike trails in the area and it gives information based on the cyclist's expertise level. www.rcaa.org/bikemap
Mary Anne McCrea, RN, MS, ACHE, Vice President/Chief Operating Officer, St. Joseph Hospital	• We need to build in ways to address disparities in healthcare. We should establish community-based healthcare programs that speak to women, the elderly, caretakers, and children.

Panelist's Biographies

Name:	Peggy E. Falk, MPH
Title:	Manager, Health Education Division
Area of Expertise:	Health Education
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Peggy Falk, MPH has managed the Health Education Division of the Humboldt County Department of Health and Human Services Public Health Branch since 1985. These health education programs include Project LEAN (Leaders Encouraging Activity and Nutrition), Alcohol and Other Drug Prevention Programs, Tobacco Education Program, the North Coast AIDS Project, the Injury Prevention Project and the Childhood Poisoning Prevention Program. Peggy received a Masters in Public Health from the School of Public Health at the University of Hawaii-Manoa. Peggy has a bachelor's degree in Community Health and Social Science from California State University Sacramento. Peggy is a member of the California Conference of Local Directors of Health Education, the California Conference of Local AIDS Directors, past president of the American Heart Association: Humboldt Del Norte Chapter, and a past board member of the American Cancer Society.

Name:	Cheryl Hale, LVN
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Cheryl Hale provides tobacco use prevention education to middle school students through a state grant. In the past five years, she has had several various grants with ages, K-12. Cheryl Hale also works with the school nurses as a health aide. She is a licensed LVN and works summers at a school for severely handicapped students. She has sixteen years of acute care hospital experience.

Name:	Joyce M. Houston, RD
Title:	Public Health Nutritionist
Area of Expertise:	Community Nutrition
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A graduate of Cal Poly, San Luis Obispo, Ms. Houston is currently working on a Master of Arts degree in Education at Humboldt State University. Joyce is a registered dietitian and has worked in public health for30 years. She has been responsible for planning and implementing nutrition activities in the following programs: Northcoast Project LEAN (Leaders Encouraging Activity and Nutrition), Nutrition Network, Child Health and Disability Prevention, Preventive Health Care for the Aging, and Maternal and Child Health. Joyce believes in the power of the media and communicates information to promote healthy eating and increased physical activity through a weekly article in the Times Standard, through daily cooking spots on KVIQ Channel 6, and through video education projects.

Name:	Ann Lindsay, MD
Title:	Health Officer
Area of Expertise:	Public Health
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Dr. Ann Lindsay received her degree in medicine from Case Western Reserve University in Cleveland Ohio and completed residency in Family Practice at UCSF/San Francisco General Hospital. She has practiced medicine in Humboldt County since 1973, serving as Public Health Officer for the last 10 years. She is Past President of the Humboldt Del Norte County Medical Society and serves on the board of the Community Health Alliance. Dr. Lindsay advocates healthy eating and active lifestyles and tries to practice what she preaches.

Name:	Mary Anne McCrea, RN, MS, ACHE
Title:	Vice President/Chief Operating Officer
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Mary Anne McCrea has worked in the acute care hospital setting since 1971. Her clinical background has been in critical care. Mary Anne has published on various topics including mentoring, work satisfaction, healthcare leadership and performance management. She most recently co-authored a chapter on performance management in *Market-Driven Nursing: Developing and Marketing Patient Care Services: AONE leadership series.* She was an active member of the American Association of Nurses Managed Care Working Group, which authored the *ANA's Patient Bill of Rights.* She has received numerous leadership awards and recognition as well as collaborated with numerous companies and organizations. Currently she is on the Editorial Board for *Nursing Administrative Quarterly*.

Name:	Terry Raymer, MD, CDE
Title:	Diabetes Program Director, United Indian Health Services Advisor, Area Diabetes Consultant, California Region Indian Health Services
Area of Expertise:	Family Practice, diabetes, CVD Prevention
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Dr. Raymer is a lifetime California resident. Dr. Raymer earned his undergraduate degree at UC Santa Barbara. He attended Medical School at UC Davis and was a Resident with Ventura County Family Practice. Dr. Raymer has worked fourteen years with United Indian Health Services. His interest in diabetes and CVD prevention grew out of personal experiences with patients in residency and at United Indian Health. The clinic received several grants in regard to diabetes (including one from the California Endowment) over the past fourteen years that has allowed him to concentrate efforts in this regard. Dr. Raymer has worked on diabetes and CVD issues for the IHS on a local, state, and national levels including education standards, diabetes standards of care and clinical guidelines for adults and children in American Indian populations, lipid guidelines for American Indian populations, and CVD risk reduction for those with metabolic syndrome and diabetes. Presently, a team of United Indian Health staff members is working to set up a pre-diabetes and metabolic syndrome registry for diabetes and ultimately CVD prevention. CVD is the leading cause of death in American Indians.

Name:	Jennifer Rice
Title:	Natural Resources Projects Coordinator
Area of Expertise:	Non-motorized mobility
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Jennifer's background is in natural resource management, however, in recent years she has learned about non-motorized transportation and recreation planning by necessity. Jennifer and RCAA have not found these to be issues adequately addressed in the public sector. In her last eight years at RCAA, Jennifer's work has become increasingly focused on responding to the public's desire for more opportunities to walk, bicycle, use wheelchairs and strollers to travel and recreate in and between north coast communities. In the last several years, this focus has expanded to include collaborative efforts that help our community infrastructure better accommodate activity in everyday life. She and co-workers are initiating the Humboldt Partnership for Active Living.

State and Local Contacts

California Department of Health Services Resources	
California Heart Disease and Stroke Prevention Program	Melba Hinojosa (916) 552-9972 mhinojos@dhs.ca.gov
Diabetes Control and Prevention Program www.caldiabetes.org	Ann Albright (916) 552-8999 aalbrigh@dhs.ca.gov
California Obesity Prevention Initiative www.dhs.ca.gov/obesityprevention	Nancy Gelbard (916) 552-9919 ngelbard@dhs.ca.gov
California Nutrition Network www.dhs.ca.gov/cpns/network	Sue Foerster (916) 449-5385 sfoerster@dhs.ca.gov
Eureka County Resources	
Humboldt County Department of Public Health Health and Human Services	Ann Lindsay, MD Health Officer 529 I Street, Eureka, CA 95501 (707) 268-2181
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Fresno Public Forum on Heart Disease and Stroke Prevention and Treatment

Summary of Key Findings

Panelists and community members highlighted the magnitude of problems related to heart disease and stroke in Fresno and throughout the state of California and offered specific strategies to address these problems. This summary captures the key points presented by expert panelists and community members at the public forum held on March 12, 2004.

Specific Findings and Recommendations

QUESTION #1:
WHAT ARE THE THREE MOST IMPORTANT CHANGES IN CALIFORNIA THAT NEED TO BE MADE IN ORDER TO REDUCE DEATH AND DISABILITY FROM HEART DISEASE AND STROKE?

- Improve the region's air quality (and thereby diminish its effect on coronary artery disease) by beautifying the streets with trees and improving the public transportation system.
- Provide access to food vouchers, fresh fruits and vegetables, and information about appropriate food and beverage serving sizes.
- Promote health education for physicians to emphasize health and food consumption.
- The community needs to make a commitment to physical activity by increasing the number of safe and healthful opportunities for residents to walk, cycle, and play in the city parks.
- Require the entertainment industry to assist in positively influencing youth.
- For program planning, access is needed to local heart disease and stroke data.
- Allow adults (and more children) into the state's Healthy Families Program.
- Improve the public transportation system so people can visit health professionals.
- Make a commitment to universal healthcare without compromising freedom of choice.

QUESTION #2:
WHAT DO PEOPLE IN CALIFORNIA NEED TO LEARN ABOUT HEART DISEASE AND STOKE? WHAT DO PHYSICIANS AND HEALTHCARE PROFESSIONALS NEED TO LEARN ABOUT HEART DISEASE AND STROKE?

- Promote community education to help people become aware of heart disease and stroke risk factors.
- Promote public awareness of the warning signs of heart attack and stroke and how these symptoms may differ in women as compared to men.

- Incorporate simple things to increase physical activity, such as playing with the kids, walking and biking to work, and parking further away from destinations.
- Small dietary changes (for example, reducing the intake of sodas and sweets) can positively affect health and reduce the risk factors for heart disease and stroke.
- Encourage and facilitate collaboration between doctors, patients, and health plans.
- Increase physician knowledge regarding secondary prevention strategies (aspirin, beta-blockers, etc.) and prepare physicians to implement new strategies as they become available.
- Adhere to quality programs and reward successful ones.

QUESTION #3:
WHAT NEEDS TO HAPPEN IN CALIFORNIA SCHOOLS, WORKPLACES, AND COMMUNITIES TO PREVENT HEART DISEASE AND STROKE?

Schools
- Focus on serving nutritious breakfasts and lunches.
- Allow only healthful foods to be sold on campuses (including through vending machines and fundraisers).
- Fully engage all students (not just those who participate on sports teams) in physical activities, education, and fitness opportunities during school and after school.
- Offer cooking and healthful food preparation classes.
- Increase the number of school nurses on campuses to implement health education and health promotion programs.
- Open schools to the public after hours to increase opportunities for physical activity.

Workplaces
- Provide environments that encourage healthy behaviors and activities, such as exercise programs and healthy foods.
- Provide information and classes to encourage healthful lifestyles choices.
- Re-think the types of food provided at celebrations and other occasions.

Communities
- Develop pedestrian and cyclist friendly streets and trails.
- Educate about chronic disease prevention through media campaigns.
- Develop evaluation tools that measure the effects of various health education programs and media campaigns.
- Expand lay leadership programs such as “Heart Menders.”
- Develop a multi-level marketing and community outreach program to promote more community engagement and involvement such as service club education, outreach to the faith communities and the elderly, and identification of various cultural festivals for community outreach.

WHAT NEEDS TO CHANGE IN THE HEALTHCARE SETTING TO IMPROVE: A) PREVENTION OF HEART DISEASE AND STOKE, AND B) QUALITY OF TREATMENT DELIVERED TO PATIENTS WITH HEART DISEASE OR STROKE?

Prevention

- Doctors need to receive more information and training on preventive care.
- Bring diabetes and other risk factors to the front and center of the discussion on heart disease and stroke.
- Assist patients with understanding the risk factors for heart disease and stroke, and give them clear information about the tests they are having, why the tests were ordered, and what the desired outcomes are.

Quality of Treatment

- Address the shortage of healthcare professionals in Fresno County.
- Improve hospital discharge plans.
- Provide 24/7 urgent care sites in the community.
- Provide the best possible care to all patients, regardless of their insurance status.

QUESTION #5
HOW CAN WE REDUCE HEALTH DISPARITIES IN HEART DISEASE AND STROKE?

- Promote a one-page food stamp application.
- Rethink the term “non-compliant.” Many patients are labeled “non-compliant” but we don’t always know their personal and social situations.
- Promote the use of health educators and other allied health professionals.
- Develop and promote a grassroots (door-to-door) outreach campaign.
- Develop health education messages in simple terms.
- Maximize the enrollment in state healthcare programs.
- Address the bureaucratic roadblocks in communities, specifically the mobile clinic licensing and certification process.
- Prioritize public health funding; too many of the funds are invested in fighting terrorism.
- The Fresno area is bountiful with fresh fruits and vegetables; unfortunately, many agricultural workers cannot afford to buy the products they harvest.
- Promote paid benefits (sick leave) for all workers; 86% of people surveyed are without health insurance/sick leave.

Fresno Heart Disease and Stroke Prevention Public Forum:
Tables with Panelists' and Public Comments

March 12, 2004, National University, 20 River Park Place West, Fresno, CA 93720-1531.

Panelists:

Robert Bennett, MD
Practicing Cardiologist
Medical Director, Cardiovascular Outcomes
Saint Agnes Medical Center

Tim Curley
Regional Vice President
Hospital Council of Northern and Central California

Valentine A. DiCerto, RN, FNP-PA
Saint Agnes Medical Center

Judy Dorn, RN
Director, Health Services
Fresno County Office of Education

Harvey Lawrence Edmonds, MD
Diplomat, American Board of Psychiatry and Neurology
Physician Medical Outcomes Leader
Saint Agnes Medical Center

Michelle Giannetta
Heart Disease Survivor
Spokeswoman, National Coalition for Women with Heart Disease
Staff Assistant to Congressman Radanovich

Karen Kitchen, RD, MPH
Health Promotion Specialist
Blue Cross of California State Sponsored Programs

Thomas Mahoney, MD, MPH
Regional Vice President
Preventive Medicine Physician
Sequoia Community Health Centers

Reverend Walt Parry
Executive Director
Fresno Metro Ministry

Yolanda Randles
Executive Director
West Fresno Healthcare Coalition, Inc.

Ralph J. Wessel, MD
Chief of Cardiology
Kaiser Permanente Medical Center – Fresno

Planning Committee:

Catherine Quinn
Executive Director
California Health Collaborative

Kathleen Grassi
Division Manager
Fresno County Department of Community Health

Patty Minami
Nutrition Education Program Manager
University of California Cooperative Extension

Jeanette Sutherlin
UCCE Fresno County Director
UC Cooperative Extension

Yolanda Bosch
Senior Vice President, Health Initiatives
American Heart Association

Jamie Morgan
Legislative Director
American Heart Association

Barbara Tanimoto-Schmall
Executive Director, Fresno Office
American Heart Association
Western States Affiliate

Staff:

- Jeanne Emmick, State Plan and Council Coordinator, Department of Health Services, California Heart Disease and Stroke Prevention Program
- Melba Hinojosa, RN, PHN, MA, Department of Health Services, California Heart Disease and Stroke Prevention Program
- John Kurata, PhD, MPH, Acting Chief, California Heart Disease and Stroke Prevention Program
- Nan Pheatt, MPH, Secondary Prevention and Professional Education Manager, California Heart Disease and Stroke Prevention Program, California Department of Health Services
- Faye Kennedy, Program Associate, Center for Collaborative Planning
- Heather Hutcheson, Program Coordinator, Center for Collaborative Planning
- Connie Chan Robison, Director, Center for Collaborative Planning

Number Attending:
13 Audience Members
11 Panelists

Promotional Activities:
The Planning Committee for the forum forwarded the Save-the-Date flyer to local stakeholders. The Center for Collaborative Planning (CCP) sent press releases and Save-the-Date information to state representatives, county supervisors, and the American Heart Association. In addition, CCP sent press releases to local media outlets, including print, radio, and TV through Congress.org. Outlets reached include:

- California Advocate
- Fresno Bee

- Madera Tribune
- Merced Sun-Star
- Vida en el Valle
- KFSN (ABC-30)
- KGPE (CBS-47)
- KMPH (Fox 26)
- KSEE (NBC-24)
- KVPT (PBS-8)
- KCIV 99.9 FM
- KFCF 88.1 FM

Fox KMPH (Channel 26) interviewed Dr. Ralph J. Wessel and Michelle Giannetta; this brief segment, “Heart Disease”, aired March 12, 2004 during the 10:00 p.m. newscast.

1. What are the three most important changes in California that need to be made in order to reduce death and disability from heart disease and stroke?

Panelist	Most Important Changes to be Made
Reverend Walt Parry Executive Director, Fresno Metro Ministry	• Barriers to healthcare are due to: -lack of transportation -lack of insurance/cost of insurance • The healthcare system must be culturally, linguistically, and geographically appropriate. • Increase access to nutritious foods in the community and schools. • Need to improve the region's air quality. • Change school policies.
Karen Kitchen, RD, MPH Health Promotion Specialist Blue Cross of California State Sponsored Programs	• Provide access to food vouchers. • Promote access to fresh fruits and vegetables. • Many community members lack transportation to healthcare services. • Extend the Healthy Families Program to all low-income adults. • How will the state fund the Healthy Families program? • Develop and define standardized serving sizes.
Valentine A. DiCerto, RN, FNP-PA Saint Agnes Medical Center	• People can't change their behaviors overnight. • Encourage people to eat healthful foods. • Re-education must start with the children/youth. • Promote the use of food stamps to buy only healthier foods, not cigarettes, gum, candy, and chips. • Promote health education for physicians to emphasize health and food consumption. • Promote health education in schools.
Judy Dorn, RN Director, Health Services Fresno County Office of Education	• We need to promote good diets, rest, and exercise. This is simple advice but it is not easy to follow. • Eating what is quick and easy usually means eating the wrong foods—fast food with too many fats and sugars. • We are a "super-size society." Portions of food are double and triple the size from what they used to be. • Obesity and diabetes are on the increase, both of which can lead to heart disease and stroke. • Fresno county leads most of the other counties in obesity rates and lack of fitness in children. • We are role models for our children. Rushing from one activity to another does not mean that we are physically active. Too much time is spent in the car and in front of the TV, computer, or movie screen.

Panelist	Most Important Changes to be Made
Thomas Mahoney, MD, MPH Preventive Medicine Physician Sequoia Community Health Centers	• We need to make a commitment to physical activity. This will decrease blood pressure and improve weight maintenance. We are making it nearly impossible for the public to exercise--no sidewalks or bike paths. • There are sexual predators in parks. Park and public safety needs to be placed higher on the priority list. With better security, families can visit and use the parks more often. • The Fresno region has poor air quality. • Area bike paths are inaccessible and unsafe. • As a society, we need to make a commitment to a healthful lifestyle. • Improve public transportation to improve access to healthcare and improve air quality. • Make a commitment to universal healthcare without compromising freedom of choice that is cost-effective. Make this a priority and put an emphasis on disease prevention. We are not thinking broadly enough. • Encourage cities to line the streets with trees for their beauty and to improve the air quality.

Public Comments on Question#1:

Community Member	Most Important Changes to be Made
Susan Milne, RN Cardiovascular Educator Saint Agnes Medical Center	• Chronic disease prevention and education are the keys to a healthier population. • Address end-of-life issues and the amount of money we spend on caring for terminal patients. Instead, work on providing quality of life and preventing chronic diseases, not prolonging the lives of patients with terminal illnesses. • Air pollution is a huge issue in the valley. It must be remedied to help diminish its effect on coronary artery disease.
Kathleen Grassi Division Manager Fresno County Department of Community Health	• We need to focus on heart disease and stroke prevention. • We need to engage the community in the solutions. • Don't divide funding streams by body parts. • Provide funding for community education programs. • Require the entertainment industry to assist in positively influencing youth. • We need local data on heart disease and stroke, and data that is similar to cancer data. The data should be collected, analyzed, used, and shared.

Community Member	Most Important Changes to be Made
Linda Mroz, RN, MHA Community Health Project Coordinator-Kaiser Permanente *(Submitted Public Comment Form)*	• Provide healthcare access to everyone through universal healthcare. Access to healthcare may also include transportation to health facilities. • Provide physical fitness classes to all students. • Provide physical fitness in all after-school programs. • Mandate schools to teach more nutrition and preventive classes, and to offer only nutritious foods and snacks on campuses. • Remove vending machines from schools.
Daniel Kim, Jr., MPH, CHES Health Educator/Project Director Tobacco Prevention Program-Human Services System/Department of Community Health [Written comments]	• Remember that tobacco use continues to be the number one cause of death and illness. • Advocate for more taxes on cigarettes as well as more taxes on fast food.

2. What do people in California need to learn about heart disease and stroke? What do physicians and healthcare professionals need to learn about heart disease and stroke?

Panelist	Californians	Healthcare Professionals
Ralph J. Wessel, MD Chief of Cardiology Kaiser Permanente Medical Center-Fresno	• Encourage people to make lifestyle changes. • Prevention includes: stop smoking, more exercise, and a better diet.	• Play a bigger role in secondary prevention by using aspirin and beta-blockers with high-risk patients. • Provide medical therapy as a way to reduce risk and focus on secondary prevention.
Harvey Lawrence Edmonds, MD Diplomat, American Board of Psychiatry and Neurology Saint Agnes Medical Center	• The community needs to be educated about risk factors and how to modify their lifestyle. • Acknowledge it's hard to change behavior. • Sequoia Hospital has a state-mandated	• Physicians need to be prepared to implement new strategies and to learn new information and implement the necessary changes. • Physicians need to develop a way of treating asymptomatic disease with their current resources while not wasting existing resources. • Physicians need to be educated and to integrate this

Panelist	Californians	Healthcare Professionals
Harvey Lawrence Edmonds, MD (cont'd)	program for overweight children that holds parents/adults responsible for their children's cardiology health.	knowledge into their daily practice. • There should be an award for doctors, which recognizes their professionalism and responsibility; this would be a great incentive for critical thinking.
Michelle Giannetta Heart Disease Survivor Spokeswoman, National Coalition for Women with Heart Disease Staff Assistant to Congressman Radanovich	• Promote community education. Many people are not aware of their risk factors for heart disease and stroke. • Promote public education that addresses the various warning signs that women with heart disease may experience, such as back and neck pain. • Women need simple things they can learn to reduce their risks. • Encourage people to eat more fresh fruits and vegetables. • Promote more exercise. • We need to understand that many people don't visit their doctor and/or keep their medical appointments because they are afraid of the outcomes.	• Doctors should discuss risk factors with their patients. • Doctors need to discuss how risk factors differ between men and women. • Educate student nurses about heart disease and stroke.

Panelist	Californians	Healthcare Professionals
Michelle Giannetta (cont'd)	outcomes. • Encourage people when grocery shopping to park in the furthest parking space so they get some physical activity.	
Thomas Mahoney, MD, MPH Preventive Medicine Physician Sequoia Community Health Centers	• Doctors have a big influence on our kids and the community's health. • People can do simple things to increase their physical activity like playing with their kids, walking and biking to work. • Patients must become politically active and support health issues.	• Be politically active and support health issues. • The healthcare system can learn from Kaiser's cancer treatment programs. • Doctors need to develop and implement heart disease protocols that are similar to the current cancer protocols. • We need to look at quality programs and reward them for their good work in reducing risks for heart disease and stroke.
Valentine A. DiCerto, RN, FNP-PA Saint Agnes Medical Center	• Encourage doctors to incorporate new ideas, information, and techniques into their practice. • Encourage doctors to listen to the nurses. • Encourage collaboration between patients, doctors, and health plans. • Provide community education and outreach.	• We need to motivate people to stop smoking. • We need to identify the "Michelles" {Michelle Giannetta, heart disease survivor} in every community and throughout the state so they can make videos and conduct presentations.

Panelist	Californians	Healthcare Professionals
Valentine A. DiCerto, RN, FNP-PA (cont'd)	outreach. Hispanics have a higher incidence of risk factors. • People need to reduce the amount of sodas and sweets consumed. These minor changes will positively impact risk factors. • Encourage more physical exercise. • A big misconception is that people must go to the gym to get exercise. People can walk at work, in community parks, at schools and in the neighborhood. • Inform the people about the City of Fresno's "Council for Physical Fitness."	
Karen Kitchen, RD, MPH Health Promotion Specialist Blue Cross of California State Sponsored Programs	• People don't have to belong to a gym to exercise; that's a myth. • Modify what is eaten and cut back on the amount of food consumed; minor changes can have substantial results. • Encourage people to increase their activity!! Walk.	

Panelist	Californians	Healthcare Professionals
Karen Kitchen, RD, MPH (cont'd)	activity!! Walk, walk, and walk.	

Public Comments on Question #2: None

3. What needs to happen in California schools, workplaces, and communities to prevent heart disease and stroke?

3a. What needs to happen in California SCHOOLS to prevent heart disease and stroke?

Panelist	Schools
Robert Bennett, MD Practicing Cardiologist, Medical Director of Cardiovascular Outcomes, Saint Agnes Medical Center	• Provide healthier foods at schools. (Breakfast foods contain too much sugar.) • Discourage potlucks, because they contain unhealthful foods. • Discourage food for celebrations and occasions.
Judy Dorn, RN Director, Health Services Fresno County Office of Education	• The goal of Fresno County's "On the Move" program is twofold; we want the children to get a good education, to be prepared for their futures, and we want the children to have a healthy future. • Parents should have the opportunity to take cooking classes with their children. • Health educators should visit schools to provide health education. • Need to educate the students and staff in our schools about proper nutrition, stress reduction and physical fitness. • Fresno County's "On the Move" program will provide classes on making good food choices and cooking classes. Students are taught how to grocery shop and they will be wearing pedometers. • Physical education will be part of their school day. • Fresno County's "On the Move" program will screen students who might be at-risk for obesity, diabetes or high blood pressure. The school nurse will be able to work with parents to get health evaluations for students when they are needed. • Rewards that are usually given for high academic scores, attendance or good conduct will not be lunch at a fast food restaurant with the principal. Instead, the students will have a chance to walk the perimeter of the campus with the principal and talk about anything they want to talk about.

Panelist	Schools
Judy Dorn, RN (cont'd)	anything they want to talk about. • The children can introduce their parents to new foods. • The Fresno County Office of Education is very excited about this new project. • Finding a good curriculum is not difficult. What is difficult is changing the mindset of the students and staff. • Young people are wonderful to work with, but they also think that they are immortal and so they don't worry about chronic diseases.
Karen Kitchen, RD, MPH Health Promotion Specialist Blue Cross of California State Sponsored Programs	• We need to focus on students that are not involved in sports. Provide walking and other fitness programs at after-school programs and assist after-school programs with obtaining the proper sports equipment. • All grade levels should have physical education classes.
Harvey Lawrence Edmonds, MD Diplomat, American Board of Psychiatry and Neurology Saint Agnes Medical Center	• Provide classes on how to reduce risks for chronic disease through the adult education system.
Ralph J. Wessel, MD Chief of Cardiology Kaiser Permanente Medical Center – Fresno	• The communication between schools and communities needs to be improved. • The schools should be open for public use after school. • Stronger links between the community and the schools will improve the children's academics. • Schools are great facilities that are underutilized.
Reverend Walt Parry Executive Director Fresno Metro Ministry	• We need to adequately fund our schools so students are not selling candy to raise school funds. • Develop policies so that physical education is part of the curriculum. • School should provide nutritious breakfasts. • We should increase the number of school nurses. • We should not use food as a reward for good performance or behavior. • Schools should not have any alliances with fast food companies. • Provide culturally appropriate and nutritious foods.
Judy Dorn, RN Director, Health Services Fresno County Office of Education	• Need to educate staff in our schools about proper nutrition, stress reduction, and physical fitness.

Public Comment on Question #3a:

Community Member	Schools
Linda Mroz, RN, MHA Community Health Project Coordinator-Kaiser Permanente	• Provide physical fitness programs in schools and after schools programs. • Mandate schools to teach more nutrition and prevention classes. • Only offer nutritious foods and snacks on campuses. • Remove vending machines from schools.

3b. What needs to happen in California WORKPLACES to prevent heart disease and stroke?

Panelist	Workplaces
Robert Bennett, MD Practicing Cardiologist, Medical Director of Cardiovascular Outcomes, Saint Agnes Medical Center	• Encourage more healthful lifestyles in the workplace. • Employers can be instrumental in discouraging potlucks, because most contain unhealthy foods. • Discourage food at celebrations and occasions. • Provide information and classes to encourage healthful lifestyle choices in the workplace.

Public Comment on Question #3b:

Community Member	Workplaces
Daniel Kim, Jr., MPH, CHES Health Educator/Project Director Tobacco Prevention Program-Human Services System/Department of Community Health-Education and Prevention Services	• Support and encourage exercise programs.

3c. What needs to happen in California COMMUNITIES to prevent heart disease and stroke?

Panelist	Communities
Yolanda Randles, Executive Director West Fresno Healthcare Coalition, Inc.	• Identify and implement models, like the Jackson Mississippi Study, that focuses on the African-American community. • Encourage input from community members on

Panelist	Communities
Yolanda Randles, (cont'd)	program development and implementation. • Encourage community members to modify unhealthy behaviors and make healthful lifestyle changes. • Develop a more collaborative process with community agencies to improve the health and well-being of the entire population. • Create safe communities, which will enable community members to engage in physical activities such as walking and bicycling.
Robert Bennett, MD Practicing Cardiologist, Medical Director of Cardiovascular Outcomes, Saint Agnes Medical Center	• Community education on the importance of a healthful lifestyle. • Encourage the development and maintenance of user-friendly parks and bike trails in the community. • Discourage food at celebrations and special occasions.
Judy Dorn, RN Director, Health Services Fresno County Office of Education	• A program, Fresno County's "On the Move", will be staffed by health educators, school nurses, dieticians, school board members and parents. • Provide more community education on chronic disease prevention. • Fresno County's "On the Move" program will encourage parents and children to walk and/or bike together in the evenings.
Harvey Lawrence Edmonds, MD Diplomat, American Board of Psychiatry and Neurology, Saint Agnes Medical Center	• We need to implement a multi-level marketing campaign to improve health behaviors. • We need to expand the "Lay Leadership Heart Mender" program. • We need to evaluate what we are trying to do with a particular project. Evaluation and measurement tools must first be developed and this will facilitate the job of the epidemiologist. • Engage local service clubs as part of the community education efforts. • Work to partner with faith-based education. • We need to work with the Hollywood film industry to assist with the creation of health education Public Service Announcement. • Conduct community outreach through cultural festivals. • Conduct outreach to the elderly. • Develop messages that are tailored to various subgroups.
Reverend Walt Parry Executive Director Fresno Metro Ministry	• Communities should provide supervised recreational programs.

Public Comment on Question #3c:

Community Member	Communities
Linda Mroz, RN, MHA Community Health Project Coordinator- Kaiser Permanente	• Promote nutrition in the communities.

4. What needs to change in the healthcare setting to improve a) prevention of heart disease and stroke, and b) quality of treatment delivered to patients with heart disease or stroke?

Panelist	Prevention	Quality of Treatment
Tim Curley Vice President Hospital Council of Northern and Central	• We need to strategically allocate our resources. • The Center for Medical Services Quality Initiative and Joint Commission on Accreditation of Healthcare Organizations have ten standards that deal with heart disease.	• Fresno County has a shortage of healthcare professionals. • We need more beds in our facilities.
Robert Bennett, MD Practicing Cardiologist, Medical Director of Cardiovascular Outcomes, Saint Agnes Medical Center	• Doctors do not receive enough training on ambulatory or preventive care. • Patients must make a commitment to improve their lifestyles. • Diabetes and other risk factors must be brought to front and center of the discussion on heart disease and stroke.	• We need to encourage patients' involvement in their care. • Patients must take personal responsibility for their care.
Robert J. Wessel, MD Chief of Cardiology, Kaiser Permanente Medical Center-Fresno		• Promote changes in the healthcare system; the system should be more organized and less fragmented. • Promote more emphasis on preventive care.
Reverend Walt Parry Executive Director Fresno Metro Ministry	• Increase access to and provide funding for interpreters.	• We need effective hospital discharge plans that help people to get

Panelist	Prevention	Quality of Treatment
Reverend Walt Parry (cont'd)	• Need universal healthcare for the whole nation. • There needs to be a place for people to seek healthcare services regardless of their insurance coverage.	what they need. • The healthcare system needs a diverse workforce. • We need 24/7 urgent care sites in the community.
Michelle Giannetta Heart Disease Survivor Spokeswoman, National Coalition for Women with Heart Disease	• Obesity is the number one issue in our region. • We need to modify our behavior versus pill-popping quick fixes. • Provide patients with clear information about the tests they are having done, why they are having the tests done, and what the desired outcomes are. • Assist patients with understanding the risk factors for heart disease and stroke and the warning signs of a heart attack and stroke.	• Insurance carriers should not determine what kind of healthcare is received. • Patients should be treated as individuals. • Patients should ask questions as consumers.
Judy Dorn, RN Director, Health Services Fresno County Office of Education		• Provide the best possible care to all patients, regardless of their insurance status.

Public Comment on Question #4:

Community Member	Prevention	Quality of Treatment
Kathleen Grassi Division Manager Fresno County Department of Community Health	• Collect local data on obesity and other risk factors. • Promote more funding for prevention and treatment of heart disease and stroke. • Provide public education on risk factors.	• Provide more funding for treatment programs.

5. How can we reduce health disparities in heart disease and stroke?

Panelist	Opportunities to Reduce Disparities
Thomas Mahoney, MD, MPH Preventive Medicine Physician, Sequoia Community Health Centers	• Reduce fraudulent applications for food stamps. • Promote a one-page food stamp application. • We need to re-think the term "non-compliant." Many patients are labeled non-compliant, but we don't always know their personal and social situations. • Provide universal healthcare for everyone. • Promote the use of health educators and other allied health professionals.
Yolanda Randles, Executive Director \West Fresno Healthcare Coalition, Inc.	• Encourage patients and community members to exercise and eat a healthier diet. • Develop and promote a grassroots (door-to-door) outreach campaign. • Develop health education messages in simple terms.
Tim Curley Vice President Hospital Council of Northern and Central California	• Maximize the enrollment in existing state healthcare programs. • Address the bureaucratic roadblocks in communities, specifically the mobile clinic licensing and certification process. • Take healthcare services to the people through mobile clinics. • We need to re-prioritize public health funding. Too many of the funds are invested in fighting terrorism. • We need to better understand the role of poverty and the lack of jobs in underserved communities.
Ralph J. Wessel, MD Chief of Cardiology Kaiser Permanente Medical Center – Fresno	• Address the shortage of health professionals in our region. • Promote educating physicians about the risk factors for heart disease and stroke. • Promote building a medical school in the Central Valley.
Harvey Lawrence Edmonds, MD Diplomat, American Board of Psychiatry and Neurology, Saint Agnes Medical Center	• The Fresno region is bountiful with fresh fruits and vegetables. Unfortunately, many agricultural workers can't afford to buy the fruits and vegetables they pick. • Health education messages to the public should be personal, local, and meaningful. • Promote improving nutrition. • Promote accountability in education.
Reverend Walt Parry Executive Director Fresno Metro Ministry	• Recommend eliminating the requirement to fingerprint and photograph food stamp recipients because this has not deterred fraudulent misuse of the stamps. • Promote increasing FEMA funding. • Hunger and malnutrition can be viewed as a form of terrorism.

Panelist	Opportunities to Reduce Disparities
Reverend Walt Parry (cont'd)	• Do not reduce Medi-Cal reimbursement. • Promote paid benefits (sick leave) for all workers; 86% of people surveyed are without health insurance/sick leave.
Valentine A. DiCerto, RN, FNP-PA Saint Agnes Medical Center	• Begin chronic disease prevention education at a younger age. • We need a unified and countywide media and health education campaign.
Karen Kitchen, RD, MPH Health Promotion Specialist, Blue Cross of California State Sponsored Programs	• Replace the word "diet" with "healthful food choices."
Judy Dorn, RN Director, Health Services, Fresno County Office of Education	• Fresno County has a program entitled "Plant-a-Row-of-Fruit."

Public Comments on Question #5: None

Panelists' Open Microphone Comments

Panelist	Comments
Ralph J. Wessel, MD Chief of Cardiology Kaiser Permanente Medical Center – Fresno	• The state and Fresno County have a shortage of health professionals (nurses and other health-related professionals). • Provide resources to educate physicians on the issue of heart disease and stroke prevention. • Medical schools are key and will help to alleviate the professional shortage in the Central Valley.
Harvey Lawrence Edmonds, MD Saint Agnes Medical Center	• We need to encourage farmers not to destroy the fruits and vegetables that are left in the fields after harvesting. • We need to build accountability in the educational system.
Reverend Walt Parry Executive Director Fresno Metro Ministry	• Promote additional taxes. • Promote no major cuts to healthcare.
Valentine A. DiCerto, RN, FNP-PA, Saint Agnes Medical Center	• We need to educate younger people about heart disease and stroke. • We need a unified, countywide health education campaign. • Provide health classes in the 7th grade to help offset peer pressure.

Panelist	Comments
Karen Kitchen, RD, MPH Health Promotion Specialist Blue Cross of California State Sponsored Programs	• Encourage people to stop “yo-yo” dieting.

Panelist's Biographies

Name:	Robert Bennett, MD
Title:	Practicing Cardiologist, Medical Director of Saint Agnes Cardiovascular Outcomes
Area of Expertise:	Cardiology
Affiliation:	Saint Agnes Medical Center
Mailing Address:	1379 E. Herndon Ave, Fresno, CA 93720
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Biography unavailable.

Name:	Tim Curley
Title:	Regional Vice President
Area of Expertise:	Hospitals and Public Policy
Affiliation:	Hospital Council of Northern and Central California
Mailing Address:	1625 East Shaw Avenue, Suite 1398, Fresno, CA 93710
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Tim Curley has served with the Hospital Council of Northern and Central California since 1994. Prior to that he was a health policy analyst with the National Governor's Association in Washington, D.C., specializing in state-based health care reform, and a Senior Research Associate with The Health Care Advisory Board Company, also in Washington, D.C.

Name:	Valentine A. DiCerto
Title:	RN, FNP-PA
Area of Expertise:	CHF Health Care Educator
Affiliation:	Saint Agnes Medical Center
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Email Address:	diceva@samc.com
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Valentine DiCerto, RN, FNP-PA is an international public speaker, educator, trainer, author, playwright, Registered Nurse, Family Nurse Practitioner, and Physician Assistant. He is experienced in program design, development and implementation and has well-developed communication and assessment skills. Mr. DiCerto is a graduate of the UC Davis School of Medicine's Family Nurse Practitioner/Physician Assistant Program. He attended Fresno City College's Nurse Upgrade program, and received his BA in Microbiology (Cum Laude) from California State University, Fresno. Mr. DiCerto designs and provides seminars and workshops on: Customer Service, Coaching and Team Building Competencies for managers & Supervisors, Managing Multiple Priorities (Time Management), Quality Improvement, Leadership, and variations of the above based on organizational needs. He has provided in-service

training on First Impression and Patient Contact Performance Standards. Moreover, he provides clinical instruction of wound management, physical assessment, safety training and injury & illness prevention.

Name:	Judy Dorn
Title:	Director, Health Services; Program Manager
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Judy Dorn is the Director of Health Services and Program Manager of the Fresno County Office of Education. She has also worked in the capacity of Special Education Assessment Nurse; Preschool Nurse; Team Coordinator - Preschool Team; School Nurse; and Charge Nurse – Pediatrics. Ms. Dorn is a member of the California School Nurses Organization (CSNO) – Central Valley Section. In addition, she is State Chairperson for the Specialty Practice Committee, Special Education. In 2002, Ms. Dorn was given the School Nurse of the Year award. An active community member, she was Co-Chair for the CSNO Annual State Conference (2000-2001), Editor for the Central Valley Section Newsletter (199-2001), ECNI (Early Childhood Nursing Intervention) Section Chairperson (1997-1999), among other activities. In addition, Ms. Dorn's publications include: Public relations pamphlet: School Nurses Making a Difference (1992) – CSNO and Communicable Disease Flipchart (1998) – CSNO. She has presented in numerous venues on topics as diverse as "The Role of the School Nurse in Community Health" to "Safe and Healthy Preschoolers" to "Guidelines for Health Aides in Rural Districts of Fresno County".

Name:	Harvey Lawrence Edmonds, MD
Title:	Diplomat, American Board of Psychiatry and Neurology
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Affiliation:	Neurology – Healthcare Quality Management
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Dr. Harvey Lawrence Edmonds currently practices with Fresno Neurological Associates. He has been a Quality Improvement Leader with Medicine Service Line, and is Interim Director of the Physician Quality Improvement Program, Saint Agnes Medical Center, Fresno (1998-Present). A graduate of UCLA School of Medicine, Dr. Edmonds interned with Harbor General Hospital and was a resident with the UCLA School of Medicine and VA Wadsworth Hospital Center. His post graduate education includes an Advanced Training Program In Healthcare Delivery Improvement, Intermountain Health, Salt Lake City, from July-November 1998. In addition, he served as Assistant Clinical Professor of Neurology, UCSF Fresno Medical Branch (1984-2000). Dr. Edmonds' memberships include: Alpha Omega Alpha (1971-

Present), American Academy of Neurology (1973-Present), California Society of Industrial Medicine and Surgery (1982-Present), and Fresno-Madera Medical Society, CMA, AMA (1979-Present).

Name:	Michelle Giannetta
Title:	Staff Assistant to Congressman Radanovich
Area of Expertise:	Heart Survivor
Affiliation:	National Coalition for Women with Heart Disease
Mailing Address:	2350 West Shaw, #137, Fresno, CA 93711
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In March 1998 I awoke in the middle of the night with all of the classic symptoms of a heart attack, but didn't know it. I was 28 years old. I was taken to the emergency room and a triple by-pass was performed that same night. I was the last person anyone would consider "heart attack material" as I had no risk factors and was in excellent health. I have since had an implantable cardioverter defibrillator inserted into my chest as a precautionary measure, but I continue to lead an active lifestyle with my husband and two sons. I am a recent graduate of the Science and Leadership Symposium at the Mayo Clinic and a Spokeswoman for WomenHeart: The National Coalition for Women with Heart Disease.

Name:	Karen Kitchen, RDH, MPH
Title:	Health Promotion Specialist
Area of Expertise:	Health Education / Management Programs
Affiliation:	Blue Cross of California State Sponsored Programs
Mailing Address:	2100 Fresno Street, Suite 4, Fresno, CA 93721
Email Address:	Karen.Kitchen@Wellpoint.com
Telephone:	559-266-0290 ext.233

- Graduated from Fresno State with a Bachelor's Degree in School and Community Programs in 1985 and in 1993 with a Master's Degree in Public Health – Health Promotion option.
- Currently employed by Blue Cross of California to implement their health education/management programs for Medi-Cal members residing in Fresno County.
- Have collaborated with community partners (American Heart Association) to educate the community on heart disease and stroke prevention.

Name: Thomas Mahoney, MD, MPH
Title: Preventive Medicine Physician
Area of Expertise: Preventive Medicine
Affiliation: Sequoia Community Health Centers
Mailing Address: 2790 S. Elm Avenue, Fresno, CA 93720
Email Address: thomm@schfclinics.org
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Dr. Mahoney received his Medical Degree from the University of Massachusetts Medical School in June 1994. He served his intern year at Merced Community Medical Center before completing his residency in Preventive Medicine Residency at Loma Linda University and receiving his Master's Degree in Public Health in August 1999. After moving to Fresno, he joined Sequoia Community Health Centers in October 1999. Now Board Certified in Preventive Medicine, Dr. Mahoney "wears many hats" – working as a clinic physician, counseling on smoking cessation and weight management, administration, and assisting Dr. Phyllis Preciado with the Comprehensive Diabetes Management Program at Sequoia. In addition, Dr. Mahoney works on the Domestic Violence Prevention Committee at Sequoia and has re-written its policy on screening for domestic violence. Dr. Mahoney has also trained physicians and resident physicians on the health impacts of domestic violence and how to screen for domestic violence.

Name: Reverend Walt Parry
Title: Executive Director
Area of Expertise: Unserved consumer health and nutrition issues
Affiliation: Fresno Metro Ministry
Mailing Address: 1055 N. Van Ness, Suite H, Fresno, CA 93728
Email Address: walt@fresnometmin.org
Telephone: 559-485-1416

Executive Director of Fresno Metro Ministry since 1985. Works with staff and volunteers in increasing health care access, improving public health, decreasing hunger, improving nutrition, fostering cultural understanding, supporting community helping services, and helping the voice of the unserved be heard in health public policy issues. Graduate of Berea College, Kentucky and American Baptist Seminary of the West in Berkeley. Previously served with national denomination as a Church and Community Study Director, and as Council of Churches Director and Protestant Campus Chaplain. Convenes monthly Community Health Care Roundtables.

Name: Yolanda Randles
Title: Executive Director
Area of Expertise: Health Education-Program Development
Affiliation: West Fresno Health Care Coalition, Inc.
Mailing Address: 1135 Fresno Street, Fresno, CA 93706
Email Address: yrandleswfhcc@sbcglobal.net
Telephone: 559-264-7185

- Graduate of California State University Fresno, bachelor's degree in Health Science 1988, MPH-expected June 2006.
- Executive Director-West Fresno Health Care Coalition, agency currently provides; health education, medical referrals, and insurance enrollment
- Program Manager-March of Dimes. Trained health care professionals to implement March of Dimes programs; organized annual conference; planned and implemented outreach in rural Fresno, "Harvesting Good Health" where more than 1200 Hispanic families attended and received information about housing, health, immunizations, health insurance enrollment and physical exams.
- Program Coordinator-Valley Children Hospital. Planned and organized hospital and community wide health screenings. Over 3,000 children were screened in one year.
- Certified Sickle Cell Counselor/Educator-State Department of Health, Genetic Disease Branch. Coordinator of Valley Children's Hospital Sickle Cell Program.

Name:	Ralph J. Wessel, MD
Title:	Chief of Cardiology
Area of Expertise:	Cardiovascular Diseased
Affiliation:	Kaiser Permanente Medical Center – Fresno
Mailing Address:	7300 North Fresno Street, Fresno, CA 93720
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Dr. Wessel received his undergraduate degree from the University of Illinois Champagin/Urbana. He attended Medical School at the University of Illinois College of Medicine, Chicago. He completed an Internship/Residency/Fellowship with Valley Medical Center of Fresno – UCSF Medical Education Program. Dr. Wessel served in the United States Navy. In addition, he is Faculty in the Department of Cardiology at Valley Medical Center. He worked in the UCSF Medical Education Program, Fresno. Currently, Dr. Wessel is a Cardiologist at Kaiser Permanente Medical Center – Fresno.

California Department of Health Services Resources	
California Heart Disease and Stroke Prevention Program	Melba Hinojosa (916) 552-9972 mhinojos@dhs.ca.gov
Diabetes Control and Prevention Program www.caldiabetes.org	Ann Albright (916) 552-8999 aalbrigh@dhs.ca.gov
California Obesity Prevention Initiative www.dhs.ca.gov/obesityprevention	Nancy Gelbard (916) 552-9919 ngelbard@dhs.ca.gov
California Nutrition Network www.dhs.ca.gov/cpns/network	Sue Foerster (916) 449-5385 sfoerster@dhs.ca.gov

Fresno County Resources	
American Cancer Society www.cancer.org	ACS, Fresno County Unit 2222 W Shaw Ave, Suite 201 Fresno, CA 93711 (559) 451-0722
American Heart Association www.americanheart.org	Barbara Tanimoto-Schmall Executive Director, Fresno Office American Heart Association Western States Affiliate 7425 N. Palm Bluff Ave., Suite 101 Fresno, CA 93711 (559) 435-5246 barbarat@heart.org
Fresno County Department of Community Health	Edward L. Moreno, MD Health Officer (559) 445-3249 edmoreno@co.fresno.ca.us Kathleen Grassi, RD, MPH Division Manager (559) 445-3276 kgrassi@co.fresno.ca.us
UC Cooperative Extension, Fresno http://cefresno.ucdavis.edu/	1720 S. Maple Avenue Fresno, CA 93702 (559) 456-7285

Inland Empire Public Forum on Heart Disease and Stroke Prevention and Treatment

Summary of Key Findings

Panelists and community members highlighted the magnitude of problems related to heart disease and stroke in the Inland Empire and throughout the state of California and offered specific strategies to address these problems. This summary captures the key points presented by expert panelists and community members at the public forum held on January 12, 2004.

Specific Findings and Recommendations

QUESTION #1: WHAT ARE THE THREE MOST IMPORTANT CHANGES IN CALIFORNIA THAT NEED TO BE MADE IN ORDER TO REDUCE DEATH AND DISABILITY FROM HEART DISEASE AND STROKE?

- Focus on disease prevention by increasing fruit and vegetable consumption, increasing physical activity to achieve weight reduction and cardiovascular fitness, and decreasing tobacco use.
- Create a paradigm shift in the definition of health away from treatment of symptoms to maintenance of the healthiest, most balanced body possible. This would include real acceptance of, and coverage for, full preventive care services.
- Address the high cost of medicines and the one third of California's children who are without health insurance.
- Negotiate with pharmaceutical companies to be equal partners to help reduce healthcare costs.
- Improve the quality of secondary prevention activities.
- Gain a better understanding of the role of mass media in public education and create a campaign against issues such as smoking in movies.
- Integrate Emergency Medical Services (EMS) into existing healthcare infrastructure, so those patients are provided a rapid and reliable continuum of care.
- Educate EMS providers to conduct in-depth patient assessments; need to change our approach to public education, especially from EMS perspective.
- Use holistic and complementary medical approaches and include nutrition and physical activity.
- Encourage community collaborations.

QUESTION #2: WHAT DO PEOPLE IN CALIFORNIA NEED TO LEARN ABOUT HEART DISEASE AND STOKE? WHAT DO PHYSICIANS AND HEALTHCARE PROFESSIONALS NEED TO LEARN ABOUT HEART DISEASE AND STROKE?

Californians

- Need to know that 80% of strokes are preventable.
- Women need to learn about the early signs and symptoms of heart disease and stroke.
- Everyone should have aspirin in their home; we need to create a public education campaign about the importance of aspirin usage in treatment and prevention efforts.
- Awareness of racial and ethnic disparities in heart disease and stroke.
- Need to know how stress and depression are related to heart disease and stroke.
- Awareness that some people are at higher risk than others for high blood pressure, elevated cholesterol, high blood sugar, and excess weight.

Healthcare Professionals

- Identify risk factors and link patients and community members with community resources.
- Assist with advocacy efforts such as writing letters to obtain needed services and resources.
- Early intervention is needed because patients who get to the hospital sooner have better outcomes.
- While physicians are well-educated about treating stroke and heart disease, they need additional training on the importance of primary prevention activities such as physical activity, diet, and behavioral counseling to successfully treat problems such as obesity.
- For better outcomes, physicians should have information to make referrals to other health professionals such as nutritionists, physical therapists, and nurses who need to be involved in treatment and prevention.
- Differences in health risks and reactions to different medications in people with various genetic backgrounds.

QUESTION #3:
WHAT NEEDS TO HAPPEN IN CALIFORNIA SCHOOLS, WORKPLACES, AND COMMUNITIES TO PREVENT HEART DISEASE AND STROKE?

Schools

- Increase availability of school nurses and involve them in teaching health classes. Currently there is only one school nurse for every 6,000-8,000 students.
- Monitor food quality and create incentives to offer healthful options.
- Improve street safety so children can walk to school.

Workplaces

- Offer tax and other financial incentives for healthful activities at workplaces (e.g., sports teams, healthful cafeteria menus, exercise programs).

Communities

- Change the environment so that healthful eating and physical activity choices become easy to access.

- Through public policy, support the creation of healthy environments.
- Use asset-based strategies when working with communities to address this issue. That is, identify best practices and assets that already exist in the community, such as nurse parish programs.
- Train community members to provide health education (e.g., Latino Mom's Group).
- Create more parks and places where people can be physically active.

QUESTION #4:
WHAT NEEDS TO CHANGE IN THE HEALTHCARE SETTING TO IMPROVE: A) PREVENTION OF HEART DISEASE AND STOKE, AND B) QUALITY OF TREATMENT DELIVERED TO PATIENTS WITH HEART DISEASE OR STROKE?

Prevention
- Make use of technology to improve communication between patients and health professionals.
- Encourage the role of EMS in developing programs and technologies to assist in early detection and recognition of heart disease and stroke and instituting secondary and tertiary prevention strategies.
- Show educational tapes and videos about healthful living in medical waiting rooms.
- Provide nutrition and dietary consultation for every patient with risk factors for heart disease and stroke.

Quality of Treatment
- Improve methods of transportation, so that community members have access to care.
- Use internet to download medical information in multiple languages.
- Provide monitoring equipment to pharmacists so they can feed data directly to physicians' offices.
- Listen to client questions, concerns, fears, and respond knowledgeably.

QUESTION #5:
HOW CAN WE REDUCE HEALTH DISPARITIES IN HEART DISEASE AND STROKE?

- Use the United States Department of Health and Human Services' 2001 national standards for cultural and linguistic competency.
- Develop new institutional procedures to access interpreters.

Inland Empire Heart Disease and Stroke Prevention Public Forum:
Tables with Panelists' and Public Comments

January 22, 2004, San Bernardino County Medical Society, 925 South Mount Vernon Avenue, Suite C, Colton, CA 92324

Panelists:

Margie Akin, PhD
Anthropologist
Cultural and Linguistic Services Specialist
Molina Healthcare, Inc.

James Goss
Regional Training Manager, Inland Empire
American Medical Response

Ronald D. Graybill, PhD
Community Outreach Coordinator
Loma Linda University Medical Center

Robert Hastings
Senior Program Director
Community Health Systems, Inc.

Sally Kaiser-Dyer, BSN, MA
Coordinator, Lifestyle Management Clinic
Loma Linda Medical Center

Kenneth Lane, MD
Family Physician,
Kaiser Permanente, Fontana

Susan MacKintosh, DO
Assistant Public Health Officer
Riverside County Department of Public Health

Christine Ridley
School Nurse Coordinator
San Bernardino County Superintendent of Schools

Laurie Rogers-Eberst, RN
Chief Nurse Executive/Senior Vice President
Past President, San Bernardino Chapter of American Heart Association
Saint Bernardine's Medical Center

Jeanne Silberstein, RD, MPH
Nutrition Services Director
San Bernardino County Department of Public Health

Pat Tyler, RN, CCRN
Regional Director of Quality Improvement Initiatives
American Heart Association

Lourdes Vizcaino
Health Initiatives Director
American Heart Association

Jon Erik Ween, MD
Neurologist
Loma Linda School of Medicine

Samuel Wilson, MD
President San Bernardino County Medical Society, Chairperson for African American Health Initiative, Director of Emergency Medicine
Barstow Community Hospital

Planning Committee:

Kenneth Lane, MD Family Physician, Kaiser Permanente, Fontana	Pat Tyler, RN, CCRN Regional Director of Quality Improvement Initiatives American Heart Association
Richard Jarvis Director of Development Division of Biomedical Sciences University of California, Riverside	Jeanne Silberstein, RD, MPH Nutrition Services Director San Bernardino County Department of Public Health
Eric Frykman, MD San Bernardino County of Public Health	Pam Grogan Fund Consortium

Staff:

- Jeanne Emmick, State Plan and Council Coordinator, Department of Health Services, California Heart Disease and Stroke Prevention Program
- Melba Hinojosa, RN, PHN, MA, Department of Health Services, California Heart Disease and Stroke Prevention Program
- John Kurata, PhD, MPH, Acting Chief, California Heart Disease and Stroke Prevention Program
- Nan Pheatt, MPH, Secondary Prevention and Professional Education Manager, California Heart Disease and Stroke Prevention Program, California Department of Health Services
- Heather Hutcheson, Program Coordinator, Center for Collaborative Planning
- Faye Kennedy, Program Associate, Center for Collaborative Planning
- Connie Chan Robison, Director, Center for Collaborative Planning

Number Attending:
23 Audience Members
14 Panelists

Promotional Activities:
The Community Health Coalition of San Bernardino County contacted potential audience members, stakeholders, and media. The Center for Collaborative Planning sent press releases and Save-the-Date information to state representatives and county supervisors. *San Bernardino Sun* article published on Sunday, January 23, 24004 and video recording of the event by Channel 3.

1. What are the three most important changes in California that need to be made in order to reduce death and disability from heart disease and stroke?

Panelist	• Most Important Changes to be Made
Jeanne Silberstein, RD, MPH Nutrition Services Director San Bernardino County Department of Public Health [written comments]	• Focus on prevention. • Increase fruit and vegetable consumption. • Increase physical activity to achieve weight reduction and cardiovascular fitness. • Stop smoking.
Margie Akin, PhD Anthropologist Cultural and Linguistic Services Specialist Molina Healthcare, Inc. [written comments]	• Comprehensive health insurance needs to be available to everyone in the state. Everyone who is at-risk for heart disease and stroke needs to be under medical supervision. • Communities need to have better access to a healthful diet at a reasonable cost (time and money). • Create paradigm shift in the definition of health away from treatment of symptoms of illness to maintenance of the healthiest, most balanced body possible. This would include real acceptance of, and coverage for, full preventive care services.
Kenneth Lane, MD Family Physician Kaiser Permanente, Fontana	• Legislative changes are needed to fix and improve the current healthcare system. • We must address the high cost of medicine and the situation that we have where one third of California's children are without health insurance. • California needs to negotiate with pharmaceutical companies to be equal partners to help reduce healthcare costs. • California legislature needs to adopt a culture of fitness to address the issue of heart disease and stroke.
Susan MacKintosh, DO Assistant Public Health Officer Riverside County Department of Public Health	• Improve access to healthcare. • Tackle risk factors through community access programs such as those in schools and workplaces. • Engage media in changing social norms.
Laurie Rogers-Eberst, RN Chief Nurse Executive/Senior Vice President	• Meet the national standards set out by AHA's "Get With The Guidelines." • Ensure care for at-home treatment. • Engage health plans in the treatment of heart disease. • Reduce smoking and obesity. • Improve quality of secondary prevention activities.

Panelist	• Most Important Changes to be Made
Thomas J. Prendergast, Jr., MD, MPH Health Officer, San Bernardino County Department of Public Health	• Improve our diets and exercise patterns. • Need more public education. • Everyone should be familiar with the risk factors. • Need better follow-up with patients. • Put new emphasis on secondary prevention, that's where the fastest gains will be. • Apply evidence-based science to the care of patients.
Sally Kaiser-Dyer, BSN, MA Coordinator, Lifestyle Management Clinic Loma Linda Medical Center	• Need to change our culture and our lifestyle. • Better understand the role of mass media in public education and creating a campaign against issues such as smoking in movies. • Reducing/eliminating fast food on school campuses and offer healthier snacks. • Create mandatory physical education; support the California 5-A-Day program. • Church members need to teach each other about health. • Employers should provide incentives such as paying employees to stay healthy and providing information and education on how to stay healthy. • Create public education videos.
James Goss Regional Training Manager, Inland Empire American Medical Response	• Emergency Medical Services (EMS) needs to be fully integrated into existing healthcare infrastructure so that patients are provided a rapid and reliable continuum of care. • Promote healthcare system's acceptance of EMS as a resource. • Educate EMS providers to conduct in-depth patient assessments; need to change our approach to public education, especially from EMS perspective. • Public education must encompass the issue of access and unmet need. • Involve EMS providers in prevention activities (e.g., blood pressure screening) on a greater level. • More education to enable EMS to become integrated into health management of communities.

Public Comments on Question #1:

Community Member	Most Important Changes to be Made
Lynne Roy, RN Coordinator, Parish Nurse Program	• Community needs to collaborate more and take off the blinders. • Use holistic and complementary medical approaches and include nutrition and physical activity.

Lynne Roy, RN (cont'd)	and include nutrition and physical activity. • Take personal approach; individuals take personal responsibility for their health. • Include alternative medicine providers in planning.
Diane Wood, DrPH, MSN, RN Coordinator, African American Health Initiative	• Need primary prevention instead of secondary prevention structure. • Identify various models and replicate.
Jim Felten, MPA Administrator, San Bernardino County Department of Public Health	• Increase personal health choices. • Increase public awareness about heart disease and stroke.
Evelyn Trevino San Bernardino County Department of Public Health	• We need new partners such as law enforcement and fire department personnel to get this work done. • Create access such as transportation. • Need public education about the issue.
Julia Slininger, Health Advisor, Lumetra	• Catalog the resources in a community (per Dr. Graybill's work).
June Hibbard, RN, BS, PHN, MPH Manager, San Bernardino County Department of Public Health	• Population-based knowledge of prevention. • Healthcare provider's knowledge and action for early identification and treatment. • Healthcare provider's knowledge of current diagnostic standards and treatment modalities.

2. What do people in California need to learn about heart disease and stroke? What do physicians and healthcare professionals need to learn about heart disease and stroke?

Panelist	Californians	Healthcare Professionals
Lourdes Vizcaino Health Initiatives Director American Heart Association		• Identify risk factors and link patients and community members with community resources. • Assist with advocacy efforts such as writing letters to obtain needed services and resources. • Identify the missing links in the care and follow-up of patients such as cultural factors and barriers. • Develop better follow-up procedures in the community. • Cultural sensitivity training.

Panelist	Californians	Healthcare Professionals
Jon Erik Ween, MD Neurologist Loma Linda School of Medicine	• People need to know that 80% of strokes can be prevented. • Need to find ways to improve lifestyles and nutrition habits. • Early identification of stroke symptoms.	• Prevention efforts must start early and we need to teach people the symptoms of stroke. • Information on prevention of stroke and heart disease and encourage patients to go to the hospital sooner.
Laurie Rogers-Eberst, RN Chief Nurse Executive/Senior Vice President Past President, San Bernardino Chapter of American Heart Association Saint Bernardine's Medical Center	• Women need to learn about the early signs and symptoms of heart disease and stroke. • Everyone should have aspirin in their home; we need to create a public education campaign about the importance of aspirin usage in treatment and prevention efforts.	• Early intervention is needed and patients who get to the hospital sooner have better outcomes.
Jeanne Silberstein, RD, MPH Nutrition Services Director San Bernardino County Department of Public Health)		• While physicians are well-educated about treating stroke and heart disease, they need additional training on the importance of primary prevention activities such as physical activity, diet, and behavioral counseling to successfully treat problems such as obesity. • More training in effective counseling techniques, current physical activity guidelines, and nutrition education. • For better outcomes, physicians should have information to make referrals to other health professionals such as nutritionists, physical therapists, and nurses who need to be involved in treatment and prevention.

Panelist	Californians	Healthcare Professionals
Margie Akin, PhD Anthropologist Cultural and Linguistic Services Specialist Molina Healthcare, Inc.	• Human anatomy and nutrition. • Awareness of racial and ethnic disparities in heart disease and stroke. • Relationships between various chronic diseases such as diabetes and heart disease. • Relationship between stress, depression, and related conditions with heart disease and stroke. • Early symptoms of acute events. • Preventive lifestyle changes and how to accomplish them.	• Need to move away from generalizations when it comes to education and treatment. We have to understand that while the educational content may be the same, the delivery and the understanding of the content may take different forms in different communities. • Differences in health risks and reactions to different medications in people with various genetic backgrounds. • Daily challenges that people have in developing healthy lifestyles. • Understand what patients really know about heart disease and stroke. • Understand patient's perception of illness and disease. • How to talk with patients to help them make incremental changes in real life situations.
Sally Kaiser-Dyer, BSN, MA Coordinator, Lifestyle Management Clinic Loma Linda Medical Center	• Stroke and heart disease can happen to anyone. Those who exercise and eat a healthful diet may still be at-risk. • How the wall of our arteries break down, pathophysiology of atherosclerosis and how the wall of the endothelium functions. • Awareness that some people are at higher risk than others for risk factors such as high blood pressure,	• Physicians and healthcare professionals need support and engagement of media to do more public education on early signs and symptoms.

Panelist	Californians	Healthcare Professionals
Sally Kaiser-Dyer, BSN, MA (cont'd)	cholesterol, blood sugar, and weight. • Warning signs for heart disease are different for women than men.	

Public Comment on Question #2:

Community Member	Californians	Healthcare Professionals
June Hibbard, RN, BS, PHN, MPH Manager, San Bernardino County Department of Public Health	• Basic understanding of the cause of heart disease and how to prevent and treat it.	• Keep updated on prevention and treatment.

3. What needs to happen in California schools, workplaces, and communities to prevent heart disease and stroke?

3a. What needs to happen in California SCHOOLS to prevent heart disease and stroke?

Panelist	Schools
Christine Ridley School Nurse Coordinator San Bernardino County Superintendent of Schools	• Improve nutrition at schools in cafeteria and vending machines such as reducing fat and salt intake. • Health classes and a greater focus on health education. • More exercise programs for students and promotion of more physical activity. • Increase availability of school nurses, which currently is at a level of only one school nurse for every 6000-8000 students and involve them in health classes.
Jeanne Silberstein, RD, MPH Nutrition Services Director San Bernardino County Department of Public Health	• Need nutrition standards.
Bill Lawrence, Deputy Director of Public Health, Riverside County Department of Public Health	• Need lesson plan on how to teach nutrition and physical education. • Control school lunch programs.

Panelist	Schools
Margie Akin, PhD Anthropologist Cultural and Linguistic Services Specialist Molina Healthcare, Inc.	• Restore health education and physical education. • Monitor food supply and create incentives to businesses that offer healthful options.
Lourdes Vizcaino Health Initiatives Director American Heart Association	• Gain control of school lunch programs.

Public Comment on Question #3a:

Community Member	Schools
Evelyn Trevino, San Bernardino County Department of Public Health	• Improve street safety so children can walk to school.

3b. What needs to happen in California WORKPLACES to prevent heart disease and stroke?

Panelist	Workplaces
Bill Lawrence, Deputy Director of Public Health, Riverside County Department of Public Health	• Workplace wellness programs are needed in Riverside County.
Margie Akin, PhD Anthropologist Cultural and Linguistic Services Specialist Molina Healthcare, Inc.	• Tax and other legislative incentives for healthful activities at workplaces (e.g., sports teams, healthful cafeteria menus, exercise programs).
Ronald D. Graybill, PhD Community Outreach Coordinator Loma Linda University Medical Center	• Create new stairwell guidelines to encourage exercise in the workplace and schools.
Lourdes Vizcaino Health Initiatives Director American Heart Association	• Implement workplace wellness programs with incentives (lower insurance premiums, wellness as an evaluation criterion).

Public Comments on Question #3b: None

3c. What needs to happen in California COMMUNITIES to prevent heart disease and stroke?

Panelist	Communities
Jeanne Silberstein, RD, MPH Nutrition Services Director San Bernardino County Department of Public Health	• Change environment so that healthful choices become easy to access and conducive to healthful eating, physical activity. • Public policy needed to support the creation of healthy environments. • Government should model healthful living. • Create mixed land use so walking is possible.
Bill Lawrence, Deputy Director of Public Health, Riverside County Department of Public Health	• In Riverside county, we need a "healthy community collaborative."
Margie Akin, PhD Anthropologist Cultural and Linguistic Services Specialist Molina Healthcare, Inc.	• Link community resources and activities to healthcare programs, especially disease management programs.
Ronald D. Graybill, PhD Community Outreach Coordinator Loma Linda University Medical Center	• Use asset-based strategies when working with communities to address this issue. • Identify best practices and assets, such as nurse parish programs. • Use community partners for collaboration. • Train community members to provide health education (Latino Mom's group). • Develop non-traditional approaches to address prevention efforts. • Focus on "livable design" for community planning and development and engage non-traditional partners such as architects to help plan environments and communities that are amenable to walking, healthful lifestyle, and physical activity.
Lourdes Vizcaino Health Initiatives Director American Heart Association	• Increase the number of walking trails. • Create more parks and places where people can be physically active.

Public Comment on Question #3c:

Community Member	Communities
June Hibbard, RN, BS, PHN, MPH Manager, San Bernardino County Department of Public Health	• Provide regular, consistent messages for prevention and treatment. • Provide opportunity and incentive for prevention and disease management activities

4. What needs to change in the healthcare setting to improve a) prevention of heart disease and stroke, and b) quality of treatment delivered to patients with heart disease or stroke?

Panelist	Prevention	Quality of Treatment
Margie Akin, PhD Anthropologist Cultural and Margie Akin, PhD Linguistic Services Specialist Molina Healthcare, Inc.	• Health has moved from, historically, infectious disease control to our current state of chronic disease conditions. The healthcare system needs to make this delivery of care transition to accommodate this shift. • Make use of technology to communicate with patients and other health professionals (e.g., e-mail).	• Patients need to see their doctors and healthcare providers on a regular basis for better outcomes. • Staff needs more training on how to collect data from patients. • Lack of transportation leads to community members not being able to access care (seek treatment). • Language barriers present challenges. Perhaps use websites to download information and signs in various languages. • Provide monitoring equipment to pharmacists so they can feed data directly to physicians' offices.
Sally Kaiser-Dyer, BSN, MA Coordinator, Lifestyle Management Clinic Loma Linda Medical Center	• Prevention services should be reimbursable. • Identify the symptoms of heart disease and stroke for women and educate both women and men about these symptoms. • Understand and use the "Get With The Guidelines" from	• Make medications affordable.

Panelist	Prevention	Quality of Treatment
Sally Kaiser-Dyer, BSN, MA (cont'd)	American Heart Association. • Identify heart disease and stroke symptoms affecting various ethnic groups. • Become familiar with successful research models. • Doctors should support healthful lifestyle choices.	
James Goss Regional Training Manager, Inland Empire American Medical Response	• EMS must be prepared to serve at-risk communities through an emphasis on public education, behavior modification, risk factor screening and, in particular, early access to care. • EMS has a role in developing programs and technologies to assist in early detection and recognition of heart disease and stroke and instituting secondary and tertiary prevention strategies.	
Kenneth Lane, MD Family Physician Kaiser Permanente, Fontana	• Everyone should come together to address heart disease and stroke. • Encourage better nutrition and eating habits, especially among youth. • Develop new guidelines for treating hypertension and diabetes. • Provide public education on nutrition.	

Panelist	Prevention	Quality of Treatment
Ronald D. Graybill, PhD Community Outreach Coordinator Loma Linda University Medical Center	• Doctors and clinics could use their waiting rooms to show educational tapes and videos about healthful living.	•
Jon Erik Ween, MD Neurologist Loma Linda School of Medicine	• Need to start thinking long-term regarding primary care. • Make sure primary care is solid and sound approaches are used.	• Need an integrated system of care. • Need to use technology more for better communications. • Measure outcomes.
Pat Tyler, RN, CCRN Regional Director of Quality Improvement Initiatives American Heart Association	• All patients should receive information on the importance of taking aspirin and smoking cessation. • Use the "Get With The Guidelines."	• Hospitals need resources and tools to assist them with delivering quality outcomes.
Jeanne Silberstein, RD, MPH Nutrition Services Director San Bernardino County Department of Public Health	• Provide nutrition and dietary consultation for every patient with risk factors for heart disease and stroke. • Include media in prevention efforts.	• Use team approach with long-term maintenance and follow-up. • Organized follow-up should be provided by other staff such as dietitians, health educators, nurses. • An integrated system of intervention is required for optimal benefits for patients.

Public Comment on Question #4:

Community Member	Prevention	Quality of Treatment
June Hibbard, RN, BS, PHN, MPH Manager, San Bernardino County Department of Public Health		• Affordable current, effective medications. • Address patient compliance to treatment plan. • Listen to client questions, concerns and fears, and respond knowledgeably.

5. How can we reduce health disparities in heart disease and stroke?

Panelist	Opportunities to Reduce Disparities
Margie Akin, PhD Anthropologist Cultural and Linguistic Services Specialist Molina Healthcare, Inc.	• Use the United States Department of Health and Human Services 2001 national standards for cultural and linguistic competency. There are 14 standards that can be adopted. • Staff should have training in cultural competency. • Translation and correct signage is needed in appropriate languages. • Develop new institutional procedures to access translators. • DHS should have a website from which signs and other information in different languages could be downloaded. • Need to correctly identify patients' various languages. • Train staff on data collection.
Lourdes Vizcaino Health Initiatives Director American Heart Association	• Work in collaboration with others in the community. • Educate community about fast foods to encourage more healthful eating. • Encourage the media to get involved. • Develop information in multiple languages. • Utilize community members as resources for education, mobilizing.
Pat Tyler, RN, CCRN Regional Director of Quality Improvement Initiatives American Heart Association	• Address secondary prevention. • Use "Get With The Guidelines", data has shown this program to eliminate gender and age disparities. Studies are currently being done to look at the effect on racial disparities.
Sally Kaiser-Dyer, BSN, MA Coordinator, Lifestyle Management Clinic Loma Linda Medical Center	• Identify differences in risk factors and disparities in outcomes and address them through media by using representatives from different cultures, races, ages, and gender. • Educate on prevalence of different risk factors within ethnic and gender groups. • Educate healthcare professionals on clinical differences for risk factors among different ethnic and gender groups.

Public Comments on Question #5:

Community Member	Opportunities to Reduce Disparities
Diane Wood, Dr.PH, MSN, RN Coordinator, African American Health Initiative	• Utilize and sustain community health advisors and build them into the primary care infrastructure.

June Hibbard, RN, BS, PHN, MPH, Manager, San Bernardino County Department of Public Health	• Market and provide services to at-risk populations.

Panelists' Open Microphone Comments

Panelist	Comments
Bill Lawrence, Deputy Director of Public Health, Riverside County Department of Public Health	• More collaboration is needed in Riverside County. • Need to share information such as best practices, tools, and resources. • Need a unified approach to address healthcare in our county. • Develop a health collaborative.
Jeanne Silberstein, RD, MPH Nutrition Services Director San Bernardino County Department of Public Health	• Need primary prevention. • Programs need to include culturally sensitive program design, advocacy, and support for policy and environmental changes to make healthful food choices and safe physical activity opportunities more available, accessible, and realistic to choose. • Conduct more research into cultural approaches for diet, physical activity, and behavioral interventions. • Social marketing is needed. • Community members should be included in the design and implementation of programs.
Samuel Wilson, MD President San Bernardino County Medical Society, Chairperson for African American Health Initiative, Director of Emergency Medicine Barstow Community Hospital	• Getting the message out about health disparities is very important. • The colorblind approach is not the best approach. • Get feedback from your patients. • Community members should be involved and are very much needed. • Churches and pastor involvement is important and needed.
Jon Erik Ween, MD Neurologist Loma Linda School of Medicine	• Develop better understanding of community resources. • Need a willingness from the community, patients, doctors, and political leaders to prevent heart disease and stroke. • Need to use American Heart Association guidelines.

Panelist	Comments
Thomas J. Prendergast, Jr., MD, MPH Health Officer, San Bernardino County Department of Public Health	• Need system change at the federal, state, and local levels to create broad movement. • Need more funds to implement the changes associated with chronic conditions. • Promote funding for lifestyle changes and systems development.
Margie Akin, PhD Anthropologist Cultural and Linguistic Services Specialist Molina Healthcare	• We have too many uninsured people who don't use the healthcare system in the same manner as those who have insurance.

Panelist's Biographies

Name:	Margie Akin, PHD
Title:	Cultural and Linguistic Services Specialist
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Dr. Margie Akin is an anthropologist who has been working as Molina's Cultural and Linguistic Services Specialist since 1999. She received her doctorate from the University of California, Riverside (UCR), and still holds the position of Associate Research Anthropologist there. Dr. Akin brings to her position as years of teaching experience and community health advocacy. Dr. Akin worked in the community on a broad range of health issues – such as opening delivery rooms to fathers in the 1970s and improving safety for psychiatric nurses at Patton State Mental Hospital in the 1980s. After having four children, she returned to school to complete her doctorate in 1992 and than taught at UCR, University of Redlands, and California State University San Bernardino. She has published on a range of topics in journals and books, including publications by the UCLA Institute of Archaeology and the Smithsonian Institution. Currently she authors a series of articles on cultural competency in healthcare for the Molina newsletter, *Partners In Care*, as well as the electronic bulletin, *Cultural Notes*, currently distributed to Molina employees in four states.

Name:	Sally Dyer, BSN, MA
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Sally is the Coordinator for the Cardiac Lifestyle Management Clinic at Loma Linda International Heart Institute. Past experience includes development of Lipid Clinics and Cardiac Risk Factor Management Clinics in Managed Care, Private Cardiology, and University Medical Center settings. She has provided preceptorship programs for medical groups across the country on how to initiate lipid and cardiac risk factor clinics and provides on-going medical staff in-servicing on the American Heart Association's "Get With the Guidelines" recommended protocol in a hospital setting. Sally is currently involved in a five-year study looking at a Physician Directed/RN Managed cardiac risk factor clinic as compared to traditional cardiac healthcare in the community after patients have been discharged from the hospital. The study is in partnership with the State of California Health Service Secondary Prevention of Heart Disease. Sally received her BSN at Loma Linda University Medical Center and her

Masters degree in Organizational and Industrial Psychology at California State San Bernardino.

Name:	James Goss
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Dr. Graybill coordinates community benefit and outreach activities for Loma Linda University Medical Center. His academic training is in American History and he focused on labor, immigration, racial justice, social reform, health, and religion issues. He directs the Norton Neighborhoods Initiative in southeastern San Bernardino, which includes a children's garden and nutrition program and also works to foster neighborhood associations and encourage their health-related activities in churches and neighborhoods.

Name:	Robert Hastings
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Name:	Dr. Kenneth Jutzy
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Dr. Kenneth Jutzy is an Associate Professor of Medicine and Head of the Division of Cardiology at Loma Linda University Medical Center. He received his medical degree from Loma Linda University where he later completed his internship and residency in the Department of Medicine. Dr. Jutzy completed a postdoctoral fellowship in Cardiology at Stanford University.

Name: Kenneth Lane, MD
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Dr. Kenneth Lane is a Family Physician with Kaiser Permanente. He is a Community Activist in the area of Public Health. He is Past President of the San Bernardino County Medical Society, Past Trustee of the California Medical Association, and Co-Founder of the Community Health Coalition of San Bernardino County.

Name: Susan MacKintosh, DO
Title: Assistant Public Health Officer
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Name: Thomas J. Prendergast, Jr., MD, MPH
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Dr. Prendergast graduated from Washington University in St. Louis with his medical degree and completed his internship in St. Louis. He then served in the Army from 1968 to 1971 and received a master's degree in public health from the University of North Carolina. He has been with the San Bernardino County Department of Public Health since 1990 and the Health Officer since 1992. He has been a member of the San Bernardino County Medical Society Board of Directors for several years and has

worked with the leadership of the SBCMS to create a focus on reducing the high coronary heart disease death rate in this county. He has lent his support to the effort to get all hospitals in this county to participate in the American Heart Association's program, "Get with the Guidelines" program.

Name:	Christine Ridley
Title:	School Nurse Coordinator
Area of Expertise:	School Health Issues
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Christine has worked extensively in education throughout her career. She was an elementary teacher for ten years, a school nurse in Riverside County for nine years, and a school administrator, coordinating comprehensive health, drug, alcohol and tobacco and HIV prevention programs for six years. She is presently working as the School Nurse Coordinator for the San Bernardino County Superintendent of Schools office serving all of the schools throughout the county. She co-wrote the *HIV Positive Prevention for California Schools Grades 7-12 Curriculum* for the American Red Cross with Dr. Kim Clark. This curriculum is currently being used in schools throughout California. Christine is also an instructor at California State University at San Bernardino, Health Science Department, instructing teachers on ways to work with health curriculum and high-risk students in the classroom.

Name:	Laurie Rogers-Eberst, RN
Title:	Chief Nurse Exec./Senior VP, Past President for San Bernardino Chapter of AHA
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Name:	Jeanne Silberstein, MPH, RD
Title:	Nutrition Services Director
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Ms. Silberstein is a developer and administrator for community-based nutrition programs and currently oversees 13 plus projects such as the *FAME* (Families of African American Ancestry Manifesting our Excellence—nutrition education to youngsters and families using traditional African dance), *Huesos Fuertes*, *Familia Saludable* (Bone Health lay educator project), Children's 5 A Day, Latino 5 A Day, the Food Hotline, Norton Nutrition Neighborhood (lay educator container and small plot gardening campaign), the San Bernardino-Riverside Counties Health Collaborative (NetCom), Regional Project LEAN and Nutrition Network.

Name:	Pat Tyler, RN, CCRN
Title:	Regional Director of Quality Improvement Initiatives
Area of Expertise:	Cardiovascular Nursing
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Patricia Tyler is the Southwest Regional Director of Quality Improvement Initiatives for the American Heart Association (AHA). She is working with hospital teams in Southern California, Arizona, Colorado, New Mexico, Nevada and Hawaii, helping them with the implementation of the new national AHA cardiovascular secondary prevention program "Get With the Guidelines[SM]". Her extensive cardiovascular nursing background has included work in ICU/CCU, Cardiac Cath Lab, Emergency Room, Coordinator of an outpatient Cardiac rehab, Case Manager for the Cardiopulmonary unit, Coordinator for a Cardiac Surgery program and Director of Cardiovascular Services. She is a member of the American Association of Critical Care Nurses and the Preventative Cardiovascular Nurses Association. She has held many positions in the health care industry as an administrator, clinician, researcher, program designer and developer of new and existing healthcare programs, with a specialization in the field of cardiovascular medicine. Patricia received a Cardiovascular Health Fellowship with Health Forum for the year 1999-2000, in which she worked with other cardiovascular medical professionals throughout the country on action learning projects designed to improve outcomes in community health and awareness. She has presented at national conferences for the AHA, American College of Cardiology, American Hospital Association, American Association of Cardiovascular and Pulmonary Rehab, the Preventative Cardiovascular Nurses Association and the Institute for Healthcare Quality Improvement. Prior to her current staff position with the American Heart Association, she had been an AHA volunteer and board member for five years.

Name:	Lourdes Vizcaino
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Los Angeles Public Forum on Heart Disease and Stroke Prevention and Treatment

Summary of Key Findings

Panelists and community members highlighted the magnitude of problems related to heart disease and stroke in Los Angeles and throughout the state of California and offered specific strategies to address these problems. This summary captures the key points presented by expert panelists and community members at the public forum held on April 1, 2004.

Specific Findings and Recommendations

QUESTION #1: WHAT ARE THE THREE MOST IMPORTANT CHANGES IN CALIFORNIA THAT NEED TO BE MADE IN ORDER TO REDUCE DEATH AND DISABILITY FROM HEART DISEASE AND STROKE?

The needed changes that panelists identified fell into three broad categories: improved primary prevention, improved access to primary care, and recognition of heart disease and stroke as a crisis that must be addressed as aggressively as any epidemic.

The panelists and members of the public suggested the following strategies for improving primary prevention:

- Build communities that make it easy and safe for people to walk, ride bikes, and be physically active.
- Make sure that people have access to affordable fresh fruits and vegetables; farmers' markets and community garden projects can help achieve this goal.
- Help people manage their weight by making scales and educational pamphlets readily available in the community in places such as supermarkets, post offices, and clinics.
- Teach people how to read food labels.
- Health plans need to encourage prevention by paying for preventive care.
- Use the power of Hollywood to teach and model heart-healthy behaviors.

To increase access to primary care, panelists recommended:

- Insurance for all.
- More affordable medications.

To increase recognition of heart disease and stroke as a health crisis, panelists recommended:

- Education for policymakers that teaches the emergency status of heart disease and stroke; people with the political or fiscal power to make change need to learn

that their children and grandchildren will have a shorter life expectancy than their own unless something is done now.
- Collection of data to underscore that California is facing a heart disease and stroke crisis; data should illuminate the prevalence of health disease and stroke risk factors as well as the burden of the diseases themselves.

QUESTION #2:
WHAT DO PEOPLE IN CALIFORNIA NEED TO LEARN ABOUT HEART DISEASE AND STOKE? WHAT DO PHYSICIANS AND HEALTHCARE PROFESSIONALS NEED TO LEARN ABOUT HEART DISEASE AND STROKE?

Californians
The discussion focused on both content of the messages, as well as how they should be presented.

With regard to content, panelists stated that Californians need to learn:
- About heart-healthy eating—what to eat, how much to eat, and how to cook it.
- About physical activity – how much and what kind of physical activity is needed for heart health and how to incorporate physical activity into everyday life.
- Symptoms of heart disease and stroke.
- That stroke is an emergency and requires immediate medical attention.

Regarding the delivery of health messages, there was acknowledgement that messages must be clear, concise, and frequent. One of the challenges noted was that the public can become confused when new science (new blood pressure guidelines, for example) replaces old familiar information.

Healthcare Professionals
According to panelists, healthcare professionals need education in two realms. First they need information that will improve their own practice of medicine with respect to heart disease and stroke. Secondly, they need to know how to educate their patients more effectively about heart disease and stroke prevention. One panelist added that if physicians learn how to interface with developers and land use planners, they can have a role in building healthier environments as well.

Panelists suggested that to improve their practice of medicine, healthcare providers should learn the importance of:
- Treating high blood pressure and high cholesterol more aggressively.
- Recognizing that different ethnic groups and women may respond differently to some medications.
- Evaluating the cardiac risk of all patients, regardless of the reason for their office visit.

With respect to patient education, panelists recommended that health professionals learn:

- How little the typical patient knows about heart disease and stroke.

- How to make health messages simple.

QUESTION #3
WHAT NEEDS TO HAPPEN IN CALIFORNIA SCHOOLS, WORKPLACES, AND COMMUNITIES TO PREVENT HEART DISEASE AND STROKE?

Schools
Time and again, panelists emphasized that schools are a learning laboratory for lifelong healthy habits. As a result, they have a responsibility to provide an environment that supports healthy choices in addition to providing formal education on nutrition, diet, the dangers of smoking, and other risk factors.

Panelists made the following recommendations for schools:
- Make only healthy food available on campus; remove sodas and fast food vendors; mandate that cafeteria food include fruits and vegetables and low-fat dairy products.
- Establish school gardens.
- Mandate physical activity.
- Teach students to recognize the risk factors of stroke.
- Look for opportunities to provide education to parents on nutrition.
- Teachers should be role models and walk on breaks.

Workplaces
Many of the health promotion strategies that apply to schools also apply to workplaces. For example, the usual fare in vending machines and cafeterias can be replaced by healthy choices, opportunities for physical activity can be made available, and people in places of authority can model healthy behaviors. But, in addition, workplaces offer an additional health promotion opportunity, because monetary incentives can be brought to bear on both employers and employees.

Panelists included these incentives in their list of workplace wellness recommendations:

- Educate employers about the bottom-line benefits of health (e.g., reduction of sick time).
- Encourage workplace wellness programs (e.g., time and places for employees to pursue physical activity) by offering reduced worker's compensation and health insurance premiums.
- Encourage weight loss competitions between departments.
- Make only healthful foods available in the cafeteria and vending machines.
- Encourage employers to e-mail heart health tips (e.g., healthy eating strategies) to employees.
- Encourage work site health screenings.

Communities
Once again, panelists focused on the interplay between community design and health. They also underscored the importance of mobilizing communities by collaborating with community-based organizations. Their specific recommendations were:

- Promote "smart growth" which allows mixed uses; this means people can walk or bike to stores and workplaces.
- Keep parks safe so they can be used for physical activity.
- Engage community-based organizations in prevention efforts.

QUESTION #4
WHAT NEEDS TO CHANGE IN THE HEALTHCARE SETTING TO IMPROVE: A) PREVENTION OF HEART DISEASE AND STOKE, AND B) QUALITY OF TREATMENT DELIVERED TO PATIENTS WITH HEART DISEASE OR STROKE?

Prevention
Panelists agreed that at present, prevention stands outside of the healthcare system. It needs to be integrated into that system before real progress can be made. The panelists' recommendations included:

- Create a sea change in the health insurance sector so that it values and, therefore, pays for preventive services.
- Encourage a team approach to prevention; physicians can use ancillary staff for prevention education.
- Establish protocols so that every patient is evaluated for heart disease and stroke risk, regardless of their reason for seeing the doctor.
- Medications should be made more affordable so risk factors (e.g., high lipids and high blood pressure) can be controlled.

Quality of Treatment
Recommendations focused on making systems changes in our healthcare delivery system:

- Use evidence-based guidelines.
- Establish stroke centers.
- Have hospitals declare and meet quality standards for heart disease and stroke care.

QUESTION #5:
HOW CAN WE REDUCE HEALTH DISPARITIES IN HEART DISEASE AND STROKE?

To frame the discussion, panelists noted that health disparities exist not only between racial/ethnic groups, but also between genders as well as between the insured and the uninsured. In general, the panelists felt that health disparities would be reduced if medical services were delivered with the same quality to all groups. Although, this would require accommodation for those whose language or cultural orientation toward

health are different than those of their healthcare providers. Specific recommendations included:

- Enlarge the scope of research; conduct specific research on women and racial/ethnic groups and also include these populations more equitably in clinical trials.
- Apply evidence-based guidelines and best practices uniformly across all groups.
- Increase linguistically and culturally appropriate health education.

Los Angeles Heart Disease and Stroke Prevention Public Forum:
Tables with Panelists' and Public Comments

April 1, 2004, American Heart Association, Western States Affiliate Office, 816 South Figueroa Street, Los Angeles, CA, 90017-2400.

Panelists:

Tony Armada
Senior Vice President, Area Manager
Metro Service Area
Kaiser Permanente

Susan Fleischman, MD
Medical Director
Venice Family Clinic

Joyce Jones Guinyard, DC
Project Director, REACH 2010
African Americans Building a Legacy of Health Community Health Councils, Inc.

Candace Howerton, MSW
Board member, Stroke Association of Southern California
Be Well Adult Day Healthcare
American Heart Association/American Stroke Association

Netty Levine, MS, RD
Senior Clinical III, Outpatient Dietitian
Nutrition Counseling Center
Cedars-Sinai Medical Center

Valerie Loduem
Director, Cultural Health Initiatives
American Heart Association

William J. McCarthy, PhD
Associate Professor & Researcher
UCLA School of Public Health
UCLA Division of Cancer Prevention & Control Research

Noel Bairey Merz, MD
Director, Women's Clinic
Cedars-Sinai Medical Center

Ismael Nuño, MD
Chief, Cardiothoracic Surgery
University of Southern California

Katherine Aguilar Perez
Executive Director
Transportation and Land Use Collaborative

Franklin D. Pratt, MD
Medical Director
Los Angeles County Fire Department

Paul Simon, MD, MPH
Director, Office of Health Assessment and Epidemiology
Los Angeles Department of Health Services

Gene Sung, MD, MPH
Director, Stroke Center
University of Southern California

Karol Watson, MD, PhD
Division of Cardiology , Co-Director
Program in Preventive Cardiology
UCLA Medical Center

Planning Committee:

Johanna Asarian-Anderson
Director, Nutrition Program
Los Angeles County Health Department

Eloisa Gonzalez
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Yolanda Bosch
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American Heart Association
Western States Affiliate

Jamie Morgan
Legislative Director
American Heart Association
Western States Affiliate

Staff:

- Jeanne Emmick, State Plan and Council Coordinator, Department of Health Services, California Heart Disease and Stroke Prevention Program
- Melba Hinojosa, RN, PHN, MA, Department of Health Services, California Heart Disease and Stroke Prevention Program
- John Kurata, PhD, MPH, Acting Chief, California Heart Disease and Stroke Prevention Program
- Nan Pheatt, MPH, Secondary Prevention and Professional Education Manager, California Heart Disease and Stroke Prevention Program, California Department of Health Services
- Belma Gonzalez, Program Coordinator, Center for Collaborative Planning
- Heather Hutcheson, Program Coordinator, Center for Collaborative Planning
- Connie Chan Robison, Director, Center for Collaborative Planning

Number Attending:
6 Audience Members
14 Panelists

Promotional Activities:
The Planning Committee for the forum forwarded the Save-the-Date flyer to local stakeholders. The Center for Collaborative Planning (CCP) sent press releases and Save-the-Date information to state representatives, county supervisors, and the

American Heart Association. In addition, CCP sent press releases to local media outlets, including print, radio, and TV through Congress.org. Outlets reached include:

- FrontPage Magazine
- Latin Reporter.com
- LatinoLA.com
- CAPS-TV (Channel 6)
- CMAC-TV (Channels 17 and 21)
- American Reporter
- Black Voice News
- Cutting Edge - A Talk Show
- Drudge Report
- ABC Television Network - Entertainment
- CBS Entertainment
- Fox Broadcasting Company - Entertainment
- WB Network – Entertainment

1. What are the three most important changes in California that need to be made in order to reduce death and disability from heart disease and stroke?

Panelist	Most Important Changes to be Made
Joyce Jones Guinyard, DC Project Director, REACH 2010 *African Americans Building a Legacy of Health,* Community Health Councils, Inc. [written comments]	• Improve mass transit and public transportation systems so that we can take citizens out of their autos. We need to improve and increase walking and bike routes, and encourage and incentivize usage. • Encourage the development of mixed-use neighborhoods and healthy communities, e.g., "Smart Growth." • Increase the promotion of healthful foods such as whole foods, fruits and vegetables, lean meats, and low- and non-fat dairy products. We should support local efforts to improve access to quality nutrition, including farmers' markets and community garden projects.
Susan Fleischman, MD Medical Director Venice Family Clinic	• Broad-spectrum change is needed, ranging from change in the community to change in high-end medical care; but the changes should not pit each stakeholder against one another. • There is no single strategy that will be effective. • We need safe places to walk, access to groceries, and primary care coverage. • We need insurance coverage of primary care and access to secondary and tertiary care. • Patients frequently wait a long time for care, and in the meantime, they suffer.
Noel Bairey Merz, MD Director, Women's Clinic Cedars-Sinai Medical Center	• Organize the state like the North Karelia Project in Finland; fifty years ago, Finland had a high rate of death from cardiovascular disease and they changed this. We need a long-term, state-sponsored approach. • Encourage people to stop smoking. We need to regulate salt and fat in our food, and create coalitions to work on these regulations. • Improve access to primary care because, for instance, hypertension, if treated aggressively, can reduce cardiovascular disease by seventy-five percent. • Develop a government/organization strategic plan. California could initiate and partner with community organizations, etc.
Netty Levine, MS, RD Senior Clinical III, Outpatient Dietitian Nutrition Counseling	• Provide education. Take language, socioeconomic aspects, and culture into account. • Create lifestyle changes: nutrition, physical activity, medical care, and preventive care rather than post-event care. • Cut preferred physician organizations that don't cover

Panelist	Most Important Changes to be Made
Netty Levine, MS, RD (cont'd)	preventive care. • Genetics cannot be changed but environment can. • Weight management programs are needed. People should be weighed in supermarkets, post offices, and clinics. • We should emphasize activity. • In grocery stores, make brochures available regarding behavioral changes, instead of magazines. • We need to teach people how to read food labels.
William J. McCarthy, PhD Associate Professor & Researcher UCLA School of Public Health UCLA Division of Cancer Prevention & Control Research	• It is challenging for Americans to make lifestyle changes but when support is there, we can do it and follow through. • People should be permitted to eat ad lib, as long as there's plenty of water and fiber (fruits/vegetables). • We need to do the right thing and create support for people eating well because their bodies want to, and when people want to, then they can be successful. • We should advocate for looking at science and go beyond medical issues. • The Finnish North Karelia project can be looked at as a model, but remember that the population in Finland is relatively homogeneous. A homogeneous society is easier to bring to consensus than our type of society, but I agree that's the way to go.
Franklin D. Pratt, MD Medical Director Los Angeles County Fire Department	• As an emergency room doctor, I see the results of poor nutritional habits and lack of activity. People don't perceive this as a problem until it hits them personally. • There is the potential, unless things change, that we are looking at a generation of young people who will not outlive their parents. • If this were an acute disease, we would be seeing this as a public health emergency. Until we do perceive this as a crisis it won't be taken seriously. Sacramento should make this into a statewide crisis. This epidemic is the worst pandemic of all time if we look at the number of deaths and financial costs. We may need to create an artificial sense of crisis to ensure it is taken seriously.

Public Comment and Panelists' Responses on Question #1:

Community Member	Most Important Changes to be Made
Dr. Cynthia Hawthorne, Drew Medical Society, Native American Medical Association	• I am originally from the Midwest and I am amazed by the lack of effect of the medical community on the media here in Los Angeles and Hollywood. When Oprah says to read a book, everyone reads a book.

Community Member	Most Important Changes to be Made
Dr. Cynthia Hawthorne, (cont'd)	Why can't we have the same effect? • There needs to be a concerted effort on the media, especially here in Los Angeles. We need to have more effect on the media, and then we can affect legislation.
Ismael Nuño, MD Chief, Cardiothoracic Surgery University of Southern California, responded:	• I am aghast at the role models in the film industry that are setting bad examples with smoking. The industry needs to be pushed to the point where movies with smoking are rated R. We are in the process of working on this and are continuing to fight. The lobby for the film industry is huge; it is a formidable task.
Valerie Loduem Director, Cultural Health Initiatives American Heart Association, responded:	• After Oprah thought she was having a heart attack, she did a few shows with the AHA and the ASA. They were real life stories. • Television consumes most of our communities. We can't get celebrity endorsements because there is a stigma to having heart attacks and strokes. Celebrities might not be able to work. • In collaboration with healthcare agencies, we need to get the same message out "in your face".
Paul Simon, MD, MPH Director, Office of Health Assessment and Epidemiology Los Angeles Department of Health Services, responded:	• Successful interventions such as counter advertising (for example: reducing smoking) are expensive. Where do we find a revenue stream to support these interventions? We should tax soft drinks one cent; this could raise the money. But this is controversial.

2. What do people in California need to learn about heart disease and stroke?

   What do physicians and healthcare professionals need to learn about heart disease and stroke?

Panelist	Californians	Healthcare Professionals
Joyce Jones Guinyard, DC Project Director, REACH 2010 *African Americans Building a Legacy of Health,* Community Health Councils, Inc.	• We need to provide information in a consumer-friendly manner by giving simple, clear, and precise information and by encouraging incremental steps for reducing disease risk factors.	• Healthcare professionals need to know what patients don't know and don't understand about these conditions. • They need to be up-to-date on current standards of care, including formularies, specific to ethnic populations. •

Panelist	Californians	Healthcare Professionals
Joyce Jones Guinyard, DC [written comments] (cont'd	• Disease prevention and health promotion strategies are needed including: what to eat, how much to eat, how to incorporate healthier options into one's diet, and how to cook in a more healthful way. • We need to convey that physical activity is a necessity, what amounts are needed, what constitutes adequate activity and how to incorporate it into one's existing lifestyle. • Stress management techniques are needed, and the connection between emotional well-being and disease prevention needs to be made. • Short- and long-term consequences of poorly managed or unmanaged symptoms of heart disease and stroke need to be shared. [verbal comments] • Consumers need simple information on disease risk factors, disease prevention and health promotion. • People don't understand "five vegetables and fruits a day." They need more information on nutritional eating and preparing foods. • People need to be told that the thirty minutes of physical activity a day can be broken up into	• They need to understand how heart disease and stroke are connected with inactivity and poor nutrition. • They need to be clear regarding the nutritional and physical activity requirements for prevention.

Panelist	Californians	Healthcare Professionals
Joyce Jones Guinyard, DC (cont'd)	can be broken up into smaller amounts throughout the day. • People need to know the symptoms of heart disease and stroke.	
Tony Armada Senior Vice President, Area Manager Metro Service Area Kaiser Permanente	• People need to be encouraged to remain active and maintain their weight. As we get older, it is harder to get onto a recovery track. • We need to continue to fight childhood obesity. • There should be constant reminders to consumers regarding healthful lifestyles.	• Education starts with the healthcare professional.
Noel Bairey, Merz, MD Director, Women's Clinic Cedars-Sinai Medical Center	• We have done a lot of mixed-message education. "Optimal" blood pressure and cholesterol levels have shifted. • We have good scientific evidence on five healthy habits that should be communicated to the public: do not smoke, be physically active, eat nutritiously (shared as what we should be eating, not what we shouldn't), maintain a healthy weight, and that a single serving of alcohol per day can be healthful. We should do public health messaging of these five areas.	• Physicians don't know enough about these issues to realize that this is a disaster. • Primary care physicians should do more to make the message simple for patients. • We need healthcare professionals to get the message about treating hypertension and cholesterol to prevent cardiovascular incidents. • There should be some infrastructure to encourage the education of all patients on cardiovascular disease prevention messages, even if the patient comes in with a cold.

Panelist	Californians	Healthcare Professionals
Ismael Nuño, MD Chief, Cardiothoracic Surgery University of Southern California		• Advocacy is one of the most important aspects of our work. It is our duty to let the government workers understand what an emergency this has become: Every thirty-three seconds, a person in the U.S. will die of heart disease or stoke. • When we get patients on the operating table, it is already too late. As a physician, I am able to affect some behaviors of some people, but this is not enough. • People in indigent health systems won't get to a cardiologist; the cost of care will keep these patients restricted to "partial care." • We can send patients out with lots of prescriptions, but people won't buy the medications; there are too many, and they are too costly.

Public Comments on Question #2: None

3. What needs to happen in California schools, workplaces, and communities to prevent heart disease and stroke?

3a. What needs to happen in California SCHOOLS to prevent heart disease and stroke?

Panelist	Schools
Joyce Jones Guinyard, DC Project Director, REACH 2010 *African Americans Building a Legacy of Health,* Community Health Councils, Inc. [written comments]	• We need to continue working to remove sugar-laden beverages and fast foods from all schools (kindergarten-12). • We need to provide and promote fresh produce, low-fat dairy products and whole foods. • Let's look at the Berkeley School District model for establishing school gardens, and incorporating quality nutrition into the general curriculum and the cafeteria. • We need to re-evaluate current physical education requirements, and where necessary, re-establish and enforce physical education requirements statewide. • Let's support the utilization of the *School Health Index* for self-assessment and re-direction. This helps schools measure how well they are doing in this area.
Valerie Loduem Director, Cultural Health Initiatives American Heart Association	• There should be an emphasis on nutrition and physical activity in the schools. • It is now not a requirement to eat balanced meals; we need to mandate balanced meals in school cafeterias. • We need to mandate physical activity in schools. • Reading, writing and arithmetic can all be taught using the food pyramid.
Ismael Nuño, MD Chief, Cardiothoracic Surgery University of Southern California	• Parents need to be trained in nutrition so they can prepare nutritious meals for their children. It is much harder to give cucumbers and carrots to children than gummy bears. • We should send children home with report cards showing their body mass index and make the parents responsible for healthy numbers.
William J. McCarthy, PhD Associate Professor & Researcher UCLA School of Public Health UCLA Division of Cancer Prevention & Control Research	• We need to invest more resources in using schools to promote health. • We need to worry about the quality-of-life issues for obese children (not just long-term financial costs). These issues include being treated badly by peers and teachers. This may reflect on their school performance and they may not do well enough to get into college. The problem is extraordinary. • We are finally seeing policies against calorie-rich, low-nutrient foods in schools. • We need to make many more opportunities for children to eat fruits and vegetables. This will raise the likelihood of eating more fruits and vegetables at home and elsewhere.

Panelist	Schools
William J. McCarthy, PhD (cont'd)	• We have an excess of sedentary behavior. We need to have children sitting for no more than two hours a day watching TV. Some kids spend more time in front of the TV than in school. Sometimes that's because parents aren't available to involve children in other activities.
Tony Armada Senior Vice President, Area Manager Metro Service Area Kaiser Permanente	• There are opportunities for public/private partnerships. Business could partner with schools to develop play areas for physical activity.
Candace Howerton, MSW Board member, Stroke Association of Southern California *Be Well* Adult Day Healthcare American Heart Association/American Stroke Association	• There is a great need to educate people in high school and beyond about stroke risk factors.
Netty Levine, MS, RD Senior Clinical III, Outpatient Dietitian Nutrition Counseling Center Cedars-Sinai Medical Center	• I hear from the parents of obese kids: "No one has ever told me." When people come to pick up their kids from school, they can be educated. We need to educate kids in elementary schools with simultaneous education for their parents. We need education regarding labels on foods and we need to give kids hands-on experience. • Teachers should be role models and walk at breaks. • There could be thirty minutes of "walking and talking" during the school day.

Public Comments on Question #3a: None

3b. What needs to happen in California WORKPLACES to prevent heart disease and stroke?

Panelist	Workplaces
Valerie Loduem Director, Cultural Health Initiatives American Heart Association	• Workplaces should provide employees with opportunities to work out -- a walking club, for example. We would see a reduction of sick time with increased healthy lifestyle opportunities. • Vending machines should offer healthy options.

Panelist	Workplaces
Ismael Nuño, MD Chief, Cardiothoracic Surgery University of Southern California	• We need to go to employers and show them the economic gain from investing in programs to educate and maintain wellness.
William J. McCarthy, PhD Associate Professor & Researcher UCLA School of Public Health UCLA Division of Cancer Prevention & Control Research	• There has to be a way to provide incentives to employers to provide opportunities and time for physical activity.
Tony Armada Senior Vice President, Area Manager Metro Service Area Kaiser Permanente	• There could be enhanced partnerships in the workplace including screening programs, for example, for healthy lifestyles.
Netty Levine, MS, RD Senior Clinical III, Outpatient Dietitian Nutrition Counseling Center Cedars-Sinai Medical Center	• There need to be more fruits and vegetables available in the workplace. • Because of technology, people are not getting off their chairs. People need to walk up and down stairs for 15-20 minutes. • Healthy eating tips could be e-mailed to all employees. • Walking tracks could be created around buildings. • There could be departmental competitions for weight loss. • Workplaces need health makeovers, including the cafeterias. Cafeterias need to have their food assessed for healthfulness.

Public Comments on Question #3b: None

3c. What needs to happen in California COMMUNITIES to prevent heart disease and stroke?

Panelist	Communities
Joyce Jones Guinyard, DC Project Director, REACH 2010/*African Americans Building a Legacy of Health,* Community Health Councils, Inc. [written comments]	• Establish or get more involved in existing REACH-like projects designed to collaboratively engage all segments of communities in the development and implementation of disease prevention strategies. • People should take advantage of the extra hour of daylight during daylight savings time to walk.

Panelist	Communities
Katherine Aguilar Perez Executive Director Transportation and Land Use Collaborative	• We need to incorporate active living and health into community design. We need "smart growth"; healthy communities where people can walk, and don't have to drive, where kids can begin to recognize mobility options. Behavioral change will be made easier if design is made healthier. • We need systems that ensure good water and air. • We need to move our sector (development) closer to public health.
Paul Simon, MD, MPH Director, Office of Health Assessment and Epidemiology Los Angeles Department of Health Services	• Speaking for the health department, we recognize that place of residence and neighborhood are powerful predictors of healthy outcomes and influence all the forces in our society that can lead to heart disease and stroke. • Public education is critically important but if we stop there, we won't achieve what we want. • This plan needs to aggressively address policy and changes to the environment. • We need good data to underscore that this is a crisis. There has been a thirty-percent rise in obesity in Los Angeles over the last six years and it is the leading cause of premature death. An infrastructure to track data over time, including policy changes, should be built into the plan. Things that are measured are more likely to get addressed.
Ismael Nuño, MD Chief, Cardiothoracic Surgery University of Southern California	• After a cardiovascular event, there can be terrible disability, but we need to give people hope. Making even incremental changes can increase longevity.
William J. McCarthy, PhD Associate Professor & Researcher UCLA School of Public Health UCLA Division of Cancer Prevention & Control Research	• California is a model that demonstrates how a mobilized community can make a change. Just look at the changes that have occurred regarding tobacco use. Anything can happen when we mobilize all our resources.
Tony Armada Senior Vice President, Area Manager Metro Service Area Kaiser Permanente	• We need more safe parks. We should consult park directors on how to make this happen.
Netty Levine, MS, RD Senior Clinical III,	• We need to start on the state level. • We could have "Frequent Walker Cards" and have

Panelist	Communities
Outpatient Dietitian Nutrition Counseling Center Cedars-Sinai Medical Center	people earn a movie ticket or whatever. • We need websites in various languages.

Public Comments on Question #3c:

4. No What needs to change in the healthcare setting to improve a) prevention of heart disease and stroke, and b) quality of treatment delivered to patients with heart disease or stroke?

Panelist	Prevention	Quality of Treatment
Joyce Jones Guinyard, DC Project Director, REACH 2010 *African Americans Building a Legacy of Health,* Community Health Councils, Inc. [written comments]	• We should conduct provider education to ensure culturally competent communication. • We need to provide more and better patient and family education (utilizing health educators, coaches, advisors when necessary).	• We need better enforcement of quality assurance measures. • We need identification and wider utilization of best practices, including cardiac rehabilitation.
Gene Sung, MD, MPH Director, Stroke Center University of Southern California		• We need changes in our healthcare systems. We need more organization. We need to develop stroke centers and have hospitals declare and meet certain standards. • We need to develop organizational guidelines. • We provide the most basic non-controversial stroke care and yet it is underutilized. People need to be encouraged to go to places with established expertise.
Karol Watson, MD, PhD Division of Cardiology , Co-Director Program in Preventive Cardiology UCLA Medical Center	• If a patient calls and says they have started to develop chest pain, they will be told to come in immediately	• Our hospital system has to get current guidelines in place or events will occur more often.

Panelist	Prevention	Quality of Treatment
Karol Watson, MD, PhD (cont'd)	and all tests will be covered by insurance. In contrast, if another patient has been reading a lot about eating fiber and getting more exercise and has questions, they could come in, but the visit won't be covered by insurance. Our healthcare system doesn't value or pay for prevention. There is so much we can do to prevent heart disease and stroke.	
Susan Fleischman, MD Medical Director Venice Family Clinic	• The uninsured and poor live in dread of getting sick. They don't get their blood pressure taken, they don't get their cholesterol checked, and they receive no counseling. Until everyone has access to primary care, we can't make a difference in prevention. People with no insurance coverage may never access medical care. • Medications for cardiovascular disease cost $200-400 per month without insurance coverage. • When people have insurance they can come in when they have an event. When people are uninsured, they call 911 and are taken to a hospital that doesn't really want	

Panelist	Prevention	Quality of Treatment
Susan Fleischman, MD (cont'd)	them there. • The county hospital system needs to be improved. There can be a three- to six-month wait for a stress echo test.	
Netty Levine, MS, RD Senior Clinical III, Outpatient Dietitian Nutrition Counseling Center Cedars-Sinai Medical Center	• No matter what a patient sees a doctor for, their blood pressure should be taken, they should be asked, "Have you been doing exercises? Are you attempting to lose weight?" • Reimbursement is one of the things we need to change to promote services, including prevention, that are in the best interests of patients.	

Public Comments on Question #4: None

5. How can we reduce health disparities in heart disease and stroke?

Panelist	Opportunities to Reduce Disparities
Joyce Jones Guinyard, DC Project Director, REACH 2010 *African Americans Building a Legacy of Health,* Community Health Councils, Inc. [written comments]	• We should establish regulations to ensure quality standards of care are provided to all, regardless of age, gender, race or ethnicity. • We need to educate patients and family/care-givers on standards of care, healthcare rights, etc. • We need to increase opportunities for the involvement of different populations in clinical trials. • We need to create opportunities for on-going dialogues on the impact of racism and the effect of ethnic stereotyping on patient care and treatment outcomes, beginning as early as medical school.
Karol Watson, MD, PhD Division of Cardiology , Co-Director Program in Preventive Cardiology UCLA Medical Center	• We need a short-term goal of creating systems to provide access to the same life-saving prevention and treatment for everyone. • Our intermediate goal should be to conduct more research. For example: why are African Americans at more risk?

Panelist	Opportunities to Reduce Disparities
Karol Watson, MD, PhD (cont'd)	• Our long-term goal should be to create ways to make communities more conducive to healthy living. Foods that are cheapest are the worst for us and it is easier to drive than to walk. This needs to change.
Ismael Nuño, MD Chief, Cardiothoracic Surgery University of Southern California	• The Rand Corporation has studies on health disparities, as does the Kaiser Family Foundation, American College of Cardiology, etc. • Health disparities occur between the genders, not just ethnic groups.
Valerie Loduem Director, Cultural Health Initiatives American Heart Association	• We are bringing information to communities. For example, four thousand women came out for a women's health forum. People want to get their blood pressures taken, their cholesterol checked. • Insured patients are underutilizing services. They don't know what their numbers are. • Doctors are rushed and they can't answer all the patients' questions; so we need to teach people how to go to the doctor and what questions to ask during medical visits.
Gene Sung, MD, MPH Director, Stroke Center University of Southern California	• Community education has to be focused to meet the needs of different communities. We need focused messages to different communities, in different languages for different cultures. • Universal health insurance is needed. Economic disparities are tremendous. • People who have jobs are sometimes the hardest to treat. They need to decide if they can buy medications or if they can eat. • One model is to look at the "evil" health maintenance organizations. We should look at Kaiser—they are very good at preventive care.
Susan Fleischman, MD Medical Director Venice Family Clinic	• Sexism and racism are involved in health disparities. • The Federal arm of HRSA is a model regarding chronic disease management. Information is entered into a registry and used for teaching practice. Is this model applicable in more general settings? • We need a standardized approach for each patient with planned visits. This should eliminate sexism and racism. • We should know what percentage of patients has had their blood pressure taken. • We need better LDL levels, better blood pressures.

Public Comment on Question #5:

Community Member	Opportunities to Reduce Disparities
Chandra Fechtehetter Board Member American Heart Association	• We need partners from the biotech and pharmaceutical industries to conduct research on disparities. • California Healthcare Institute will be making this issue a more powerful event.

Panelists' Open Microphone Comments

Panelist	Comments
Katherine Aguilar Perez Executive Director Transportation and Land Use Collaborative	• Land use and health need to be linked. There is a relationship between walking, health, and accessibility. • As you move forward, think of new partners in this crusade. Think across sectors.
Franklin D. Pratt, MD Medical Director Los Angeles County Fire Department	• We don't have a healthcare system; we have a disease treatment system. Prevention is another piece of the pie and needs to be given its due. • We need to look at a reward system in disease management funded by research money. • State money should be spent on prevention. • Medical students need to be trained in social skills. The healthcare disease treatment side doesn't choose people who are good at preventive care.
William J. McCarthy, PhD Associate Professor & Researcher UCLA School of Public Health UCLA Division of Cancer Prevention & Control Research	• Quality of life needs to be factored in when encouraging dependency on the medical system. There are differences in mortality and morbidity if you don't rely on medication. If we aren't measuring quality of life outcomes, we won't have accurate data. We want people to be healthier and happier without dependency on the medical system.
Tony Armada Senior Vice President, Area Manager Metro Service Area Kaiser Permanente	• Advocacy is important. We should support the following legislation: Hancock AB 2200 (school breakfast program), Jackson AB 2686 (school lunch program), Escutia SB 1556 (ban beverages sodas in schools), Dunn SB 1821 (raise the legal smoking age to 21). • We need to restrict the amount of fat in school lunches.

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Anthony A. "Tony" Armada is the Senior Vice President and Area Manager for Kaiser Permanente's Metropolitan Los Angeles Service Area. Before joining Kaiser Permanente, Mr. Armada served as Senior Vice President and Chief Operating Officer of Northridge Hospital Medical Center in Northridge, California and as President and Chief Executive Officer of Chino Valley Medical Center in Chino, California. With over twenty-two years of experience in the healthcare field, Mr. Armada is known for his focus on market and program development, leadership development, operational turnaround efforts, physician relationships and partnerships, strategic efforts toward quality enhancement and high patient and employee satisfaction. In the last three years, Mr. Armada has also been very involved in community and civic activities, including the Board of Directors of the Los Angeles Area Chamber of Commerce, the Board of Directors of the American Heart Association, Los Angeles Chapter, and the Transitional Board of the Filipino American Community of Los Angeles organization (FACLA). He is also an Advisory Board member of the CORO Foundation Leadership in Healthcare initiative and has played a leadership role in the formation and designation of Historic Filipinotown in Los Angeles. Mr. Armada received his bachelor's degree in Medical Technology from Michigan State University and his master's degree in Hospital Administration and in Business Administration from Xavier University in Ohio. He is a Diplomate of the American College of Healthcare Executives and serves on the adjunct faculty of California State University, Northridge, Xavier University and the University of LaVerne for their master's Programs in Healthcare Administration. Mr. Armada also serves on the board of the Hospital Council of Southern California.

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Dr. Susan Fleischman became the Clinic's first Medical Director in 1989. Trained in Internal Medicine at the University of California Los Angeles, her pioneering efforts and powerful vision of health care with dignity and efficiency were highly instrumental in transforming the original clinic from a tiny, fledgling operation into a model of accessible,

quality, cutting-edge health care that inspires communities and physicians nationwide. Since 1987, Dr. Fleischman has been an Assistant Clinical Professor of Medicine at the UCLA School of Medicine, General Internal Medicine Division. In this capacity, she teaches residents on site at the Venice Family Clinic as well as sees patients herself. Dr. Fleischman actively lectures on community medicine, homeless healthcare issues, and managed care contracting with community based organizations. She is the President-elect of the California Primary Care Association Board of Directors; President of District 5 of Los Angeles County Medical Association; and Acting Chair of the National Advisory Council to the National Health Service Corps.

Name:	Joyce Jones Guinyard, DC
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Dr. Joyce Jones Guinyard is the Project Director of Community Health Council's (CHC) REACH 2010 Project, *African American Building a Legacy of Health*, a national health initiative funded by the Centers for Disease Control and Prevention. As a CHC staff member, Dr. Guinyard has also provided leadership for health promotion projects through the South Los Angeles, Inglewood, Lennox, and Hawthorne Community Health Councils. She has spent the past 25 years advocating for quality health care for women and children and remains committed to empowering consumers, and community capacity building. Dr. Guinyard is currently a member of the African American Task Force for the California Nutrition Network's 5-A-Day program and Los Angeles County Regional Cancer Detection Partnership-Partnered for Progress (PFP); and sits on the boards of PFP and South Central Unit of the American Cancer Society. She has served as advisor to a number of health advocacy projects, including the South Central Prevention Coalition, Black Women for Wellness, Western Consortium for Public Health's *Women's Health Leadership* program and the California Wellness Foundation's *Children and Youth Community Health Initiative*.

Name:	Candace Howerton, MSW
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Candace Howerton's new life started 12 years ago when she suffered a massive stroke on August 9, 1992. All she knew about stroke was you had to be 70 years old before you started worrying about it. Now, she feels very differently. Candace was born in San Diego and got her start at the Old Globe Theatre. She is a former actor, writer, and production coordinator for over 30 years. Being disabled at 49 is a devastating event and Candace worried whether anyone would even want to hug her after her stroke.

She had a lop-sided smile, walked with a decided limp, had limited use of her right hand, and she could not talk, unless you understood what “mama, mama” meant. Ms. Howerton’s self-confidence was at its lowest. When she was placed on SSDI, she was grateful, but Candace stated, “I’m a survivor, not a victim!” After leading a stroke support group for six years, Candace decided to enroll at the California State University and graduated with a bachelor’s degree in Psychology in 1998 and she then went on to achieve a master’s degree in Social Work from University of Southern California in 2002. Candace sits on the board of the Stroke Association of Southern California and is a speaker for same, and is also a speaker for the American Heart (Stroke) Association. She has given over a hundred speeches since 1993. She is now a national speaker. Candace also created a visitation program called “You Are Not Alone” for stroke survivors and caregivers in the hospital and at home.

Name:	Netty Levine, MS, RD
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Netty Levine, MS, RD began working as a registered dietitian at CSMC in 1978. In her 26 years of service at Cedars-Sinai, she has utilized her knowledge and skills as a registered dietitian to help thousands of patients take control of their eating habits and live healthier lives. As a dietitian in the outpatient Nutrition Counseling Center, she provides medical nutrition therapy for adult or pediatric outpatients with various diagnoses such as diabetes, kidney disease, cardiovascular disease, obesity, pregnancy, diabetes in pregnancy, and eating disorders. She has spoken to many community groups and high school students on the benefit of good nutrition. When not counseling patients, Netty frequently provides nutrition expertise for several print and broadcast media (NBC, ABC, CBS, KCAL, UPN, KCOP, the Discovery Channel, KKGO 105.1. (Kmozart) Radio Station, Fight Back-Talk Back with David Horowitz on the local and national levels). She has been interviewed or participated in writing articles for the following publications and websites: the *LA Times, Family Circle Magazine*, *Woman's Day, Prevention* magazine, the *Jewish Journal*, WebMD, *Beverly Hills Weekly*, Jewish Post of New York on line, and Pregnancy Today on line.

Name:	Valerie Loduem
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In 2001, Valerie Loduem was hired by the American Heart Association as the Director of Professional Education. As the Director, she was responsible for implementing continuing education symposiums geared towards high-level physicians and other

healthcare professionals. Additionally, she established relationships with the top pharmaceutical companies in the nation. In her first year with the AHA, Valerie's Annual Fall Symposium was the highest attended, highest grossing symposium. In February of 2002, Valerie was promoted to the Director of African American Programs and Operation Stroke. In this position, Valerie's main objective is to educate African-Americans and Latino's about the perils of cardiovascular disease and stroke. She writes grants to fund all at-risk programs, creates, and implements programs that target and educate high risk populations about risk factors, prevention, diabetes, nutrition, obesity, exercise, stress management and exchanging unhealthy lifestyles for healthy ones. To date, her programs have educated more than 300,000 people, to live heart healthy lives. Programs such as *Search Your Heart*, *Hip Hop Rock Your Heart*, *The Blind Have Hearts Too*, *African-American Women & the Perils of Heart Disease*, and *Fit at Fifty* have made an important impact. Additionally, Valerie has worked with several hospitals in the Los Angeles area educating physicians and administrators of the importance in implementing Primary Stroke centers in their facilities. Valerie has a strong passion and desire to work with the community in invoking healthy lifestyles and maintain adequate resources for healthcare.

Name:	William J. McCarthy, PhD
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Dr. McCarthy's research focus includes survey studies of tobacco use and tobacco cessation patterns among adults and school age children with a focus on ethnic differences, as well as intervention studies of diet and physical activity patterns targeted to African American women and low-income elementary school and middle school students. Dr. McCarthy is a past recipient of the "Health Fitness Leader" award from the Los Angeles County Board of Supervisors and past recipient of the "Capitol Dome" award from the American Cancer Society for his career of public service.

Name:	Noel Bairey Merz, MD
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Dr. C. Noel Bairey Merz is Medical Director of the Preventive and Rehabilitative Cardiac Center at Cedars-Sinai Medical Center. Board certified in internal medicine, cardiovascular diseases and medical examination, she is also Holder of the Women's Guild Chair in Women's Health and Medical Director of the Women's Health Program at

Cedars-Sinai. Dr. Bairey Merz also serves as an Associate Professor of Clinical Medicine for the Department of Medicine at the University of California, Los Angeles (UCLA) School of Medicine. Dr. Bairey Merz's primary area of research interest involves the development and prevention of heart disease in women, including the role of nutrition, exercise and stress. She is Chair of the NIH sponsored multi-center study, Women's Ischemic Syndrome Evaluation (WISE), which is investigating the potential for more effective diagnostic and evaluation methods of coronary artery disease in women. Dr. Bairey Merz has received investigational grants from the National Institutes of Health, American Society of Nuclear Cardiology and the American Heart Association. A prolific lecturer, Dr. Bairey Merz is a member of several professional organizations, including the American College of Cardiology, American Heart Association, Academy of Behavioral Medicine Research and the American Society for Preventive Cardiology. Dr. Bairey Merz is currently the national spokesperson for VHA's Women's HeartAdvantage campaign to raise awareness of heart disease in women. She has been published in numerous peer-reviewed publications, including *Cardiology Today*, *Journal of Women's Health*, *American Heart Journal* and the *Journal of the American Medical Association*. She also has been interviewed for articles in *The New York Times*, *U.S. News & World Report* and *Time Magazine*, and she has appeared on network television programs, including *Good Morning America*, *20/20*, and *Dateline*. Dr. Bairey Merz has been appointed to the Board of Trustees of the American College of Cardiology, where she is a Fellow, as well as the chair of the Prevention of Cardiovascular Disease committee. Her other professional associations include being a member of the International Society and Federation of Cardiology's Scientific Council on Rehabilitation of Cardiac Patients, and the NIH Risk, Prevention and Health Behavior Study Section 2. Dr. Bairey Merz received her bachelor's degree from the University of Chicago and her medical degree from Harvard University. She completed her residency at the University of California, San Francisco, where she served as Chief Medical Resident. Dr. Bairey Merz also completed fellowships in clinical cardiology and nuclear cardiology at Cedars-Sinai Medical Center.

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Dr. Ismael Nuño is the Chief of Cardiac Surgery at the LAC+USC Medical Center in Los Angeles. He is also the current President for the AHA, Western States Affiliate. He is a cardiac surgeon affiliated with The University of Southern California, Keck School of Medicine. He received his training in Cardiothoracic Surgery at the Walter Reed Army Medical Center in Washington, DC and has been with USC for the last eight years. Dr. Nuño is on staff at eight major hospitals in Los Angeles (Huntington Memorial, Methodist Hospital, USC University Hospital, etc.) His interest is the standardization of cardiovascular health care for the people of California, particularly the Latino population in Southern California.

Name: Katherine Aguilar Perez
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Katherine Aguilar Perez is the Executive Director of the Transportation & Land Use Collaborative of Southern California (TLUC). Katherine is a professional transportation planner with experience in national policy, regional planning and local government. The Collaborative (formerly known as the Southern California Transportation & Land Use Collaborative) is the first organization created to promote solely for the linkages between transportation and land use. Since its formation June 1, 2000, the Collaborative has been published in the Los Angeles Times and has met with key legislators and numerous policy makers in the region. Before coming to TLUC, Katherine served as the Deputy Mayor to the first city-wide elected Mayor, William Bogaard, in Pasadena, California. She worked on a variety of issues including transportation, land use, and planning. With a professional background in transportation, she was able to work with the Latino community on many projects, including the Metro Gold Line Light Rail Extension, a 13-mile transit line from Los Angeles to Pasadena that opened in July 2003. She currently serves on the CORO Foundation Board of Directors, a leadership development organization, and is a member of the Urban Land Institute Executive Council in Los Angeles. She serves as a member of the Traffic Relief Task Force recently created by Los Angeles Mayor James Hahn and is a member of the Integrated Resource Plan Steering Committee for the Los Angeles Bureau of Sanitation and Department of Public Works. She is a popular featured speaker and panelist at many conferences and other public events. Katherine received her master's degree in Urban Planning and Transportation from UCLA and her bachelor's degree in Political Science from Cal State Northridge.

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Dr. Pratt is the Medical Director of the Los Angeles County Fire Department and the Medical Director of the emergency department. At Torrance Memorial Medical Center, he has been an emergency physician for over 20 years. His professional interests are focused on emergency medical services and the public health overlap. Cardiac care and the prevention of heart and vessel disease are two areas of concern. Dr. Pratt initiated Automatic External Defibrillations in Los Angeles County in 1988 and oversees paramedic care of patients in 2300 square miles of Los Angeles.

Name:	Paul Simon, MD, MPH
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Dr. Simon received his medical degree from the University of Michigan and Master's Degree in Public Health from UCLA. He completed a residency in Pediatrics at Kaiser Sunset in Los Angeles and was a staff pediatrician with Kaiser for three years. Dr. Simon completed a two-year fellowship in field epidemiology (Epidemic Intelligences Service) with the Centers for Disease Control and Prevention and remained with the CDC for six additional years as a Medical Officer with the Division of HIV/AIDS Surveillance, assigned to Los Angeles County. He has been in his present position for six years and is responsible for tracking health trends in the county population. His particular areas of interest include chronic disease and maternal-child health issues.

Name:	Gene Sung, MD, MPH
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Dr. Sung has recently moved to Los Angeles to become director of the Neurocritical Care and Stroke Section at the University of Southern California (USC). He received his medical degree from the University of Minnesota and was trained in neurology at the University of Maryland. He then trained in Neurocritical care at the Johns Hopkins Hospital, and while on the faculty, he also completed a Masters in Public Health in Epidemiology at Johns Hopkins University. He started a program in Neurocritical Care and Stroke at the University of Colorado, before moving to California. He has leadership positions in the American Stroke Association, the National Stroke Association and the American Academy of Neurology, and is a founding member and the President of the Western States Stroke Consortium. He has had papers published in a variety of journals and is also a reviewer for several and is the Associate Editor for the new journal, Neurocritical Care. Dr. Sung has been the director of many different medical courses and has given numerous invited lectures and presentations.

Name:	Karol Watson, MD, PhD
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Dr. Karol E. Watson received her medical degree from Harvard Medical School and her PhD in Physiology from the University of California at Los Angeles. She completed a residency in Internal Medicine at UCLA's School of Medicine, and continued there to pursue a fellowship in Cardiovascular Diseases. She subsequently became a part of the UCLA Specialty Training and Academic Research program and was awarded the position of Chief Fellow in Cardiovascular Diseases at the school. Currently, Dr. Watson contributes to the UCLA community in a variety of roles. She serves as the Co-Director for the UCLA Program in Preventative Cardiology and as a Director for their Center for Cholesterol and Hypertension Management. She is an Assistant Professor of Medicine at UCLA's Division of Cardiology and is the Assistant Director for the UCLA Fellowship Program in Cardiology. Dr. Watson has received many honors including "America's Top Physician" award from Black Enterprise magazine and the Robert Wood Johnson Minority Medical faculty Development Award. She has also appeared in USA Today, the Los Angeles Times, Woman's Day magazine, on Lifetime television, NBC News, and the radio program "Bev Smith Show." She serves as a reviewer for several journals, including *Journal of the American Medical Association, Annals of Internal Medicine*, and *Circulation*, and is on several boards, including the scientific advisory board for WomanHeart and the advisory board for the California Heart Disease and Stroke Prevention program. She is also the chairperson for the Cholesterol Committee of the Association of Black Cardiologists. Dr. Watson's current research focuses on oxidized phospholipids and angiogenesis, and the role of estrogen in OX-PAPC induced angiogenesis, but her more than 60 publications and presentations have also addressed many other subjects from academic careers and hormone replacement to metabolic syndrome X in African Americans and hypercholesterolemia in females.

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Dr. Antronette K. Yancey is an associate professor in the Department of Health Services, UCLA School of Public Health, with primary research interests in chronic disease prevention intervention and adolescent health. She has recently returned to academia full-time after five years in public health practice, first as Director of Public Health for the city of Richmond, VA, and, until recently, as Director of Chronic Disease Prevention and Health Promotion, Los Angeles County Department of Health Services. Dr. Yancey has authored more than 50 scientific publications, including peer-reviewed journal articles, briefs, book chapters, and health promotion videos. She has generated more than $13 million in extramural funds, including 2 R01 grants as principal investigator. She has also served on a number of national Boards of Directors including, the Public Health Institute, and peer review boards/committees including her current Associate Editor role with *Health Psychology*. Dr. Yancey completed her undergraduate studies in biochemistry and molecular biology at Northwestern

University, her medical degree at Duke, and her preventive medicine residency/MPH at UCLA. She is a basketball enthusiast and poet/spoken word artist. Her book of poetry and art, a collaboration with artist Todd Berrien, *An Old Soul with a Young Spirit: Poetry in the era of desegregation recovery*, was released in 1997, and her spoken word music CD, a collaboration with musicians Ciro Hurtado and Kim Jordan, was released in 2001.

California Department of Health Services Resources	
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Diabetes Control and Prevention Program www.caldiabetes.org	Ann Albright (916) 552-8999 aalbrigh@dhs.ca.gov
California Obesity Prevention Initiative www.dhs.ca.gov/obesityprevention	Nancy Gelbard (916) 552-9919 ngelbard@dhs.ca.gov
California Nutrition Network www.dhs.ca.gov/cpns/network	Sue Foerster (916) 449-5385 sfoerster@dhs.ca.gov
Los Angeles Resources	
Los Angeles County Physical Activity and nutrition Task Force	Cynthia Harding Program Director, Co-Chair LA County Department of Health Services, Maternal, Child & adolescent Health Programs 600 S. Commonwealth Avenue, Suite 800, Los Angeles, CA 90005 (213) 639-6400/fax 639-1033 charding@dhs.co.la.ca.us
New Schools Better Neighborhoods	Johanna Asarian-Anderson, MPH, RD LA County Department of Health Services Nutrition Program 2530 Wilshire Blvd., Suite 800 Los Angeles, CA 90010 (213) 351-7889/Fax 351-2793 janderson@dhs.co.la.ca.us
New Schools Better Neighborhoods www.nsbn.org	811 West 7th Street, Suite 900 Los Angeles, CA 90017 (213) 488-0737
Livable Places www.livableplaces.org	634 South Spring Street, Suite 727 Los Angeles, CA 90014-3902 (213) 622-5980/fax 622-3458

Sacramento Public Forum on Heart Disease and Stroke Prevention and Treatment

Summary of Key Findings

Panelists and community members highlighted the magnitude of problems related to heart disease and stroke in Sacramento and throughout the state of California and offered specific strategies to address these problems. This summary captures the key points presented by expert panelists and community members at the public forum held on February 27, 2004.

> *Note: Prior to the Public Forum, a group of clinical and research physicians from UC Davis Medical Center, specializing in the areas of heart disease and stroke prevention and treatment, spent two hours with the staff of CHDSP. These physicians responded to the same questions that were asked at the public forum later that same day. The physician group responses will be included in this summary along with the Sacramento Public Forum.*

Specific Findings and Recommendations

QUESTION #1:
WHAT ARE THE THREE MOST IMPORTANT CHANGES IN CALIFORNIA THAT NEED TO BE MADE IN ORDER TO REDUCE DEATH AND DISABILITY FROM HEART DISEASE AND STROKE?

The Sacramento panelists are intent that a statewide large-scale public education campaign needs to be launched focusing on heart disease and stroke as being essentially preventable diseases that remain leading causes of death and disability. Risk factor education for the higher risk populations is also considered a critical part of the educational campaign.

- Create a statewide, large-scale, public education and media campaign focusing on the concept that heart disease and stroke are leading causes of death and disability and these diseases are essentially preventable with risk factor reduction.
- Focus on teaching higher risk populations, such as women, who rarely recognize heart disease or stroke as a personal threat; African Americans, who are at high risk for hypertension; and Hispanics, who are at high risk for type 2 diabetes.
- Improve primary prevention and use social marketing to address nutrition and obesity.
- Improve knowledge of risk factors for cardiovascular disease.
- Encourage personal responsibility for health outcomes.
- Improve and mobilize the entire healthcare system, including dentistry, optometry, ophthalmology, primary care and gynecology to actively screen for/counsel/advocate for recognition and treatment of risk factors for heart disease and stroke.
- Find psychological approaches to reduction of risk factors.

- Monitor outcomes and interventions to see what is working.
- Develop a regional approach to manage stroke and heart disease to direct patients to high volume centers with excellent outcomes and low complication rates, particularly as treatments become more sophisticated and the expense of maintaining these teams and facilities rise.

QUESTION #2:
WHAT DO PEOPLE IN CALIFORNIA NEED TO LEARN ABOUT HEART DISEASE AND STOKE? WHAT DO PHYSICIANS AND HEALTHCARE PROFESSIONALS NEED TO LEARN ABOUT HEART DISEASE AND STROKE?

The Sacramento panelists stressed repeatedly that people need to learn about risk factors and symptoms of heart disease and stroke, and they need to understand that these diseases are essentially preventable. The panelists also stressed that people need to take responsibility for their own health. They need to reduce risk factors themselves. People also need to know the warning signs of heart attack and stroke because early treatment is essential to saving lives and preventing disability. Physicians and healthcare professionals need to adhere to treatment guidelines, know the importance of prevention guidelines and management of risk factors and be aware of the critical clinical "Golden Hour" for the effective treatment of cardiovascular disease. They also need to be good listeners and use clear, simple language to explain things to their patients; frequently patients do not understand what they are being told.

Californians
- Know that certain subsets of heart disease and stroke are preventable and not determined by genetics.
- Behavioral and lifestyle modifications are powerful methods for primary and secondary prevention of heart disease and stroke.
- Address health problems that are not causing pain or other noticeable symptoms.
- Learn to reduce risk factors and assume personal responsibility for health, by eating better, exercising regularly, and stopping smoking.
- Change the public perception of heart disease and stroke prevention.
- Focus on the warning signs of stroke and emphasize the timeliness of treatment.
- Change population behaviors.

Healthcare Professionals
- Have knowledge of and adhere to current treatment guidelines and outcome assessments.
- Provide data on health prevention benefits and strategies for teaching effective risk factor modification.
- Educate patients about the importance of medications and lifestyle changes.
- Understand the importance of preventive management of risk factors, such as hypertension, diabetes, elevated lipid levels, and tobacco.
- Increase awareness of the critical importance of the clinical "Golden Hour."

- Cardiologists and stroke specialists need to work regionally to develop specialized networks to direct care of patients to advanced centers and to effectively reintegrate the patients back to their community physicians following stabilization.

QUESTION #3:
WHAT NEEDS TO HAPPEN IN CALIFORNIA SCHOOLS, WORKPLACES, AND COMMUNITIES TO PREVENT HEART DISEASE AND STROKE?

California schools are critical sites for education about heart disease and stroke and risk factors. The panelists also concur that unhealthy foods need to be replaced in schools with nutritious foods and there physical activity should be mandated. At California worksites, the expert panel reported, unhealthy foods need to be replaced with nutritious foods. Exercise should be encouraged, as well as educational programs about heart disease and stroke. The work in the community should start with primary prevention with children since our children are not eating right and exercising, and life habits are established early. Additionally, the community needs to promote non-motorized transportation.

The expert panelists note that health education and coordination of emergency medical services and hospital services regionally are also major issues that need to be resolved if we are determined to reduce death and disability due to cardiovascular disease.

Schools
- Use this setting for education and prevention of heart disease and stroke; including parent education.
- Replace unhealthy foods (fast food, vending machines) with nutritious meals.
- Develop educational programs to raise public awareness about risk factors for heart disease and stroke.
- Remember that every moment is teachable. Educate parents through children, remembering the success of the tobacco education campaign.
- Send strong messages about nutrition and risk factors.
- Increase physical education classes.
- Teach about vascular disease and how this can lead to a damaged heart and/or brain.

Workplaces
- Eliminate unhealthy foods and vending machines.
- Provide health education classes.
- Provide healthy, nutritious meals.
- Encourage exercise.

Community
- Commit to improving heart disease and stroke risk and outcomes.
- Change children's behavior; increase physical activity.
- Send strong messages about nutrition and risk factors.

- Health education and coordination of EMS and hospital services regionally are the biggest issues facing communities.
- Promote non-motorized transportation.

QUESTION #4:
WHAT NEEDS TO CHANGE IN THE HEALTHCARE SETTING TO IMPROVE: A) PREVENTION OF HEART DISEASE AND STOKE, AND B) QUALITY OF TREATMENT DELIVERED TO PATIENTS WITH HEART DISEASE OR STROKE?

The Sacramento panelists feel that a system shift to improve *prevention* is critical because the healthcare system now focuses time and resources on advanced disease care management. While healthcare access would achieve higher levels of prevention, a cardiovascular disease risk profile on every patient (coming to a clinic for any reason) would jumpstart both the patient and the healthcare system in its efforts for prevention. That same system would plug high-risk patients into a cardiovascular disease clinic. Educational programs for both patients and healthcare providers on recognition of symptoms of heart disease and stroke are recommended. The *quality of treatment* would be improved if a multidisciplinary education program would be developed that could integrate nutrition, exercise and psychology. Additionally, we need the development of population registries with built-in tracking and modeling. The registries would show how many have had various blood bests and link the information to evidence-based guidelines. Quality in the area of stroke will require more intense research on preventing and dealing with brain injury.

Prevention
- Provide access to healthcare.
- Focus on prevention versus advanced care management.
- Provide a cardiovascular disease risk profile for all patients.
- Require that insurance companies and HMOs support preventive care.
- Educate physicians, nurses, and patients in prevention.
- Improve recognition of signs and symptoms of stroke and heart disease.
- Transition doctors from dealing with episodic events to dealing with a person's total health.
- Provide high-intensity disease management and case management for greater public health impact.
- Provide benchmarks for prevention that are established and are supported by reimbursement.

Quality of Treatment
- Create report cards and systems to implement established evidence-based guidelines.
- Develop multidisciplinary education, integrating nutrition, exercise, and psychology.
- Change the focus from doctor-patient to partners.
- Promote a commitment from the healthcare delivery system and the state to reduce emergency room crowding.
- Develop population registries with built-in tracking and modeling.
- Coordinate services and goals of treatment.

- Develop breakthroughs to reduce brain injury and improve outcomes.
- Support stroke centers and EMS changes consistent with patient diversion.
- Measure quality.
- Use physician audits to improve the quality of care.

QUESTION #5:
HOW CAN WE REDUCE HEALTH DISPARITIES IN HEART DISEASE AND STROKE?

Better access to the healthcare system could diminish disparities, as would an education campaign with culturally and linguistically appropriate language. Evidence-based guidelines are needed; disparities will change with the implementation of registries. Low-income patients often cannot afford needed medications for control of diabetes and hypertension. Additionally, this population frequently lacks the education to gain the knowledge about risk factors and many must rely on using the emergency room because they do not have other options. We need to solve this set of problems

- Provide educational materials that are culturally and linguistically appropriate and geared to the right reading level.
- Initiate a statewide media campaign on cardiovascular disease risk factors and how to reduce them, focused on disparate populations.
- Identify depression, isolation, and differences in socioeconomic status that isolate people and contribute to health disparities.
- Large portions of our state populations are without healthcare access and low-income patients often cannot afford much needed medications for control of diabetes and hypertension. Additionally, this population frequently lacks the education to have the knowledge about risk factors and many must rely on using the emergency room because they have not access or other options. This problem needs to be solved.
- Learn how to address culturally diverse groups and disadvantaged populations.
- Build registries which will enhance evidence-based guidelines; disparities will change with the implementation of evidence-based guidelines.
- Consider using community-based interventions that have been proven successful, such as promotoras.
- Add questions to the drivers' test regarding heart disease and stroke.

Sacramento Heart Disease and Stroke Prevention Public Forum:
Tables with Panelists' and Public Comments

February 27, 2004, University of California, Davis, Medical Center (UCD Medical Center), Cancer Center Auditorium, 4501 X Street, Sacramento, CA.

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Carrie Sens, RN, MSN
President, California Society for Cardiac Rehabilitation

Selinda Shontz, RD
American Heart Association/American Stroke Association

Allan Siefkin, MD
Executive Director, UC Davis Medical Group, Professor of Medicine, Associate Dean, UC Davis Medical Center

Amparo Villablanca, MD
Chair, Sacramento Public Forum
Associate Professor of Internal Medicine, Division of Cardiovascular Medicine, UC Davis Medical Center, Director of the Women's Cardiovascular Health Program and Clinic, Associate Director of Women's Center for Health, UC Davis School of Medicine

Mary Wieg, MBA, RN
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President, California Society for Cardiac Rehabilitation

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Number Attending:
35 Audience Members
11 Panelists

Promotional Activities:
The Public Affairs office of UC Davis Medical Center and the American Heart Association contacted potential audience members, stakeholders, and media. The Center for Collaborative Planning sent press releases and Save-the-Date information to state representatives and county supervisors.

1. What are the three most important changes in California that need to be made in order to reduce death and disability from heart disease and stroke?

Panelist	Most Important Changes to be Made
Amparo Villablanca, MD Chair, Sacramento Public Forum Associate Professor of Internal Medicine, Division of Cardiovascular Medicine, UC Davis Medical Center, Director of the Women's Cardiovascular Health Program and Clinic, Associate Director of Women's Center for Health, UC Davis School of Medicine [written comments	• We should create a statewide large-scale public education campaign focusing on the concept that heart disease and stroke are leading causes of death and disability and these diseases are essentially preventable. • We need to educate all groups, globally, and high-risk populations, specifically (women, African Americans, Hispanics). • There should be a focus on children to prevent diabetes and obesity. • We need to deal with healthcare access and reduce health disparities. [verbal comments] • I conducted an education program for patients starting with a survey about patients' knowledge of their health and heart disease. The majority of patients do not know that heart disease is the leading cause of death among men and women, and they do not know that it is preventable. • There should be an educational focus on educating higher risk populations such as women; African Americans, who are at higher risk of hypertension; and Hispanics, who are at higher risk of diabetes. • We should focus on children to prevent future risks especially since there is an epidemic of obesity and • There should be the creation of specific education programs type 2 diabetes. • There is an issue of access for higher risk groups and specific populations. • Providing access for high-risk populations can assist with reducing health disparities. for the various cultural groups in California. • There needs to be a sense of urgency around healthcare access and reducing health disparities.
Michael L. Carl, MD, FACEP Chief, Emergency Services Kaiser Permanente, South Sacramento [written comments]	• Universal, comprehensive healthcare for our entire population needs to occur, with reasonable access. • There needs to be improved education of our children on the risks of tobacco and alcohol and drug abuse, and the importance of diet and exercise. • There needs to be re-allocation of state budget resources to healthcare and education.

Panelist	Most Important Changes to be Made
John Yao, MD, MPH, MBA, MPA, FACP Senior Medical Director Blue Shield of California [written comments]	• We need to reduce the smoking rate. • We need to reduce borderline and high blood pressure. • We need to reduce the obesity rate. • We should enhance public education and organize community-based programs to facilitate these goals.
Carrie Sens, RN, MSN President, California Society for Cardiac Rehabilitation	• Public education about heart disease and stroke is critical. • Work with patients to modify risk factors. • We need education, clinical practice procedures, and early identification of risk factors and symptoms of heart attack and stroke. • There should be outreach and focus on ethnic communities. • We need comprehensive disease management. • The promotion of AHA guidelines should occur. • We need to get information out to fellow co-workers. Outreach needs to be done at health fairs, workplaces, and with the media. We need to get the information out with a focus on ethnic communities and religious centers. • We should encourage local media to broadcast health reports. • More than half the population dies due to heart disease, and stroke is the third leading killer. • The high cost of cardiovascular disease--everyone is paying for it. We are talking about $30.4 billion dollars. Cardiovascular disease is affected by life style factors such as physical inactivity. Smoking costs us $75 billion dollars, $33 billion dollars will be spent due to poor nutrition, obesity will cost is $117 billion dollars; diabetes will cost $132 billion dollars. • We should pick one thing for an intervention, such as physical activity and exercise; it can change most of the risk factors especially high blood pressure. Ninety-percent of people over thirty years of age will have high blood pressure at some point in their lives. • Prevention will help us solve problems.
Allan Siefkin, MD Executive Director, UC Davis Medical Group, Professor of Medicine, Associate Dean, UC Davis Medical Center	• We need an earlier recognition and diagnosis of acute events with appropriate treatment medication. With any individual, this may reduce the degree of potential disability. • We need more funding to address heart disease and stroke prevention. • Currently, most of the dollars spent for healthcare for

Panelist	Most Important Changes to be Made
Allan Siefkin, MD (cont'd)	these two conditions are spent in the terminal phase of life. • We should increase recognition of the risk factors across communities. • We should intervene effectively to prevent or delay cardiovascular disease. • Increase spending on prevention; currently, most of the dollars spent for healthcare for these two conditions (heart disease and stroke) are in the terminal phases of life. • We need to decide that evidence-based prevention is a wise investment. There is not as much evidence as we would like but it is accumulating. The best evidence in this area is for cigarette smoking, obesity and diabetes, hypertension, and hyperlipidemia. • We need to decide what populations we will cover and what we will we focus on. Increasing the tobacco tax to $5 is not enough to do all this. • We need to be able to identify new risk factors.
John A. Bissell, MD Chief of Neurology Kaiser Permanente South Sacramento	• Controlling patients' hypertension, diabetes, and obesity is important. • The brain is not a robust organ, but the heart is—cardiologists are way ahead of neurologists. There is a need for more robust neurological data. • Obesity needs to be addressed. We need to get people to exercise and we need increased public education.
Mary Wieg, MBA, RN CalPERS Office of Health Policy and Plan Administration, Health Maintenance Organization Contracts and Compliance Unit	• Everyone must take personal responsibility for his or her own health outcomes. • It is cheaper to prevent disease than to deal with problems after the fact. • Everyone should know and understand the risk factors. Examples: smoking, obesity and lack of physical exercise. • We need to provide incentives to people to do the right thing regarding eating and healthy lifestyles. • We need to make changes in our society so that the fat and calories information for fast food is available and prominent. • Thirty-percent of Americans put off treatment due to cost. • It is not acceptable that sixty-percent of the population is overweight.

Public Comments on Question #1:

Community Member	Most Important Changes to be Made
Ann Miller Dietary Intern, Kaiser Permanente	• As a future health educator, I agree that education is key for patients, family members, staff, and physicians. We need to educate people about obesity, smoking, and exercise.
Forrest L. Junod, MD Medical Director Sutter Heart Institute Sutter Medical Center Sacramento	• I agree there is a need for education, improved access, and personal responsibility in healthcare. • I still doubt that heart disease can be (preventable) – "eliminated" which seems to be the thrust of the panel. • Incidence and disability may be reduced or delayed in every productive way. Death by failure of heart or brain remains the way most people die even as they live longer having controlled other disease processes.
Paul Akins, MD, PhD Medical Director, Mercy Stroke Center [written comments]	• Improve and mobilize the general public's understanding of what they can do to identify the major risk factors for heart disease and stroke and to treat these (both lifestyle and manage medical diseases actively with their doctors/healthcare professionals). • As a stroke neurologist and director of the Mercy Stroke Center, I see an enormous burden of patients hurt by strokes that could be prevented due to poorly controlled hypertension, obesity, lack of knowledge of benefits of warfarin for atrial fibrillation, and out of control diabetes. • Improve and mobilize the entire healthcare system including dentistry, optometry, ophthalmology, primary care, and gynecology to actively screen for/counsel/advocate for recognition and treatment of risk factors for stroke and heart disease. • We need to develop a regional approach to manage stroke and heart disease to direct patients to high volume centers with excellent outcomes and low complication rates, particularly as treatments become more sophisticated and the expense of maintaining these teams and facilities rises. The data already show that the high volume cardiac interventionists and surgeons have better complication rates. • The data regarding thrombolytic therapy for stroke patients are probably the subject of publication bias. In Cincinnati, community hospital patients treated with tPA had high mortality, particularly when they were not treated according to guidelines. Other community centers (such as the Mercy Stroke Center in Sacramento) have reported outcomes comparable to

Community Member	Most Important Changes to be Made
Paul Akins, MD, PhD (cont'd)	Sacramento) have reported outcomes comparable to the NINDS tPA stroke study. • Treatment of patients with cerebral aneurysms is another example of how specialized treatment is critical for favorable outcomes, and higher volume centers definitely are an advantage for patients in need of complex treatment.

2. What do people in California need to learn about heart disease and stroke?

   What do physicians and healthcare professionals need to learn about heart disease and stroke?

Panelist	Californians	Healthcare Professionals
Amparo Villablanca, MD Chair, Sacramento Public Forum Associate Professor of Internal Medicine, Division of Cardiovascular Medicine, UC Davis Medical Center, Director of the Women's Cardiovascular Health Program and Clinic, Associate Director of Women's Center for Health, UC Davis School of Medicine	• We need to make people aware that cardiovascular disease is the leading cause of death and there needs to be awareness that this is a preventable disease. • We need to share the benefits of lifestyle modifications and link these modifications to the risk factors to disease. • Education equals prevention, which equals improved outcomes. [verbal comments] • There are a number of well-crafted and based current guidelines that need to be implemented. We need to see if this will result in improved outcomes and there will be a reduction of death and disability.	• Healthcare professionals need to know and adhere to current treatment guidelines and an outcomes assessment. • More data on health prevention benefits and strategies for teaching effective risk factor modification are needed. • There should be a focus on the use of aspirin, statins, ACE-I, beta-blockers, and Therapeutic Lifestyle Changes (TLC) • [verbal comments] • If doctors provide information to patients, they need data to show it will reduce risks. • We need healthcare professionals to educate patients about the importance of aspirin usage, AHA guidelines, and TLC.

Panelist	Californians	Healthcare Professionals
Michael L. Carl, MD, FACEP Chief, Emergency Services Kaiser Permanente, South Sacramento [written comments]	• The public needs to be educated about the direct association of heart disease and stroke with tobacco abuse, poor management of hypertension and diabetes, and sedentary lifestyles.	• Healthcare professionals need to understand the importance of the preventive management of risk factors, such as hypertension, diabetes, elevated cholesterol and lipids, and tobacco abuse. • Additionally, physicians need to be aware of the significant risk reductions that are attainable through the use of aspirin, beta-blockers, and dietary changes.
John Yao, MD, MPH, MBA, MPA, FACP Senior Medical Director Blue Shield of California [written comments]	• The general public needs to know that certain subsets of heart disease and stroke are preventable and not determined by genetics. • Behavioral and life style modifications are powerful (and probably more effective) for primary and secondary prevention of heart disease and stroke. • The public needs to take responsibility for improving their own health and commit to it: eat better, exercise regularly, and stop smoking. [verbal comments] • The general public needs to understand the importance of reducing the smoking rate. • Also, they should know about reducing borderline and high blood pressure (based on new, stricter	• The following quote is from *Journal of the American Medical Association, JAMA, 2004 Feb4:291(5):565-75:* ". . . the majority of stroke survivors still have significant risk of subsequent (recurrent) stroke, and well-tested interventions to eliminate stroke recurrence are not available." The same can be said for heart disease patients and heart attack survivors. • Aggressive optimization of medical <u>and</u> behavioral approaches for risk reduction and quality of life need to be followed. Physicians and other healthcare professionals can be powerful motivators for patients to change. • We need to be aware of the critical importance of the clinical "Golden Hour." • Healthcare professionals need be know about primary versus secondary versus tertiary prevention efforts and the public health impact of each.

Panelist	Californians	Healthcare Professionals
John Yao, MD, MPH, MBA, MPA, FACP (cont'd)	standards) in the population. • They should understand the importance of reducing the obesity rate. • We need to enhance public education and organize community-based programs to facilitate these goals. • People need to understand that heart disease and stroke are preventable and that heart disease and stroke are not predetermined. • Behavior and lifestyle modifications are needed. • People need to take responsibility and commit to exercise regularly, eat better, take their medications, and have surgery as needed. • People should be educated on the importance of "The Golden Hour" after an event–treating heart disease and stroke the same way as we treat trauma patients. • It is important that we have the general population taking responsibility for improving their own health.	

Panelist	Californians	Healthcare Professionals
Dianne Hyson, PhD, MS, RD Assistant Professor/Adjunct Clinical Faculty, California State University, Sacramento	• We need to change the way the public perceives heart disease and stroke prevention. We conducted surveys with patients and found that thirty-percent of people are not aware of cardiovascular risk factors. • We are such a pill-taking society. We need to change the focus on personal responsibility. • Obesity underlies and exacerbates every risk factor for cardiovascular disease. • We need to educate the general public that heart disease and stroke are preventable. • We need to look at the role of the media and the internet because they are top sources of information and misinformation.	
Selinda Shontz, RD American Heart Association American Stroke Association	• The average person does not understand warning signs of stroke and that time matters. We need to focus on this issue. We need public education. People need to hear our message seven to eight times to really "get it." Collaborative efforts regarding	• Healthcare professionals need to be better listeners and we need to understand that the average person does not understand what we are saying to them.

Panelist	Californians	Healthcare Professionals
Selinda Shontz, RD (con't)	public health messages should be supported. • There are too many conflicting messages. We need a collaborative effort to make an impact. We need a collaborative effort on risk factors and we need to figure out how we can do this practically and culturally appropriately. • The average person doesn't understand the information because the level of the information is too high. People walk away from healthcare providers not knowing and understanding critical information. • People need to know how to take personal responsibility.	
Carrie Sens, RN, MSN President, California Society for Cardiac Rehabilitation (cont'd)	• People need to be taught about heart disease at their bedside after an event too. • We need to educate the public on wellness, prevention, and rehabilitation.	• Coordinated efforts are necessary. For instance, there needs to be information on what it means to be disabled. People need to understand that component of heart disease and stroke • We need to take action now and act in a coordinated way showing we are all on the same program. • With the obese child, we need to get to the "heart of the mother"- to her concern for her child. We need to use words like "pre-diabetic".

Public Comments on Question #2:

Community Member	Californians	Healthcare Professionals
Ann Miller Dietary Intern, Kaiser Permanente	• People need to know their risk factors. • Make it something real to them; not reciting huge numbers which are meaningless to the public and better suited to researchers.	
Forrest L. Junod, MD Medical Director, Sutter Heart Institute, Sutter Medical Center, Sacramento	• How to reduce risk factor effects and assuming personal responsibility for healthcare. • Exercise, diet, no smoking, and medical care for treatable health problem.	• Evaluation regarding treatments. • Guidelines for primary and secondary risk reduction.
Paul Akins, MD, PhD Medical Director Mercy Stroke Center	• Healthy lifestyle choices. • How to maintain an appropriate weight and how to lose weight safely. • How to check their blood pressure and what level is dangerous. • What the warning symptoms of a heart attack and stroke are and what to do. • What the treatment goals are if they are under treatment for vascular disease risk factors and what they can do to help their doctor achieve these treatment goals.	• Importance of early intervention to prevent vascular diseases. • Aggressive risk factor modification. • Importance of teaching patients about treatment goals and how they can help to achieve them. • How to educate their patients about heart and stroke symptoms. • Cardiology and stroke specialists need to work regionally to develop specialized networks to direct the care of patients to advanced centers and how to effectively reintegrate the patients back to their community physicians after stabilization.

3. What needs to happen in California schools, workplaces, and communities to prevent heart disease and stroke?

3a. What needs to happen in California SCHOOLS to prevent heart disease and stroke?

Panelist	Schools
Amparo Villablanca, MD Chair, Sacramento Public Forum Associate Professor of Internal Medicine, Division of Cardiovascular Medicine, UC Davis Medical Center, Director of the Women's Cardiovascular Health Program and Clinic, Associate Director of Women's Center for Health, UC Davis School of Medicine [written comments]	• Use these settings for education and prevention. • Institute school lunch place education campaigns and reward schools that do the campaigns. • Eliminate unhealthy foods (meals, vending machines) from these settings and replace with nutritious meals.
Michael L. Carl, MD, FACEP Chief, Emergency Services Kaiser Permanente, South Sacramento [written comments]	• Develop educational programs to raise public awareness of the risk factors for heart disease and stroke and the fact that these diseases can be prevented through lifestyle changes.
John Yao, MD, MPH, MBA, MPA, FACP Senior Medical Director Blue Shield of California [written comments]	• Healthy, nutritious meals should be available in schools. • Early education should be provided to students on the adverse health impact of smoking, obesity, and high blood pressure. [verbal comments] • The CDC states that half of the adult population in the United States is overweight or obese. We need to cultivate good eating habits.

Panelist	Schools
Selinda Shontz, RD American Heart Association, American Stroke Association	• There should be a school educational campaign that also involves parents. • Teachers need to be role models. It is difficult to communicate the appropriate message when the teacher is eating junk food • The AHA guidelines should be utilized. • We should develop and support partnerships: schools with healthcare providers, insurance carriers, the American Heart Association, the American Diabetes Association, local grocery stores. They should all be working together to develop the same message and reinforcing one another in the message.
Dianne Hyson, PhD, MS, RD Assistant Professor/Adjunct Clinical Faculty, California State University, Sacramento	• We should remember that every moment is a teachable moment. • Progress has been made with vending machines in schools but there is a ways to go. • Coordinated efforts are needed between schools, workplaces, the cafeterias in schools and the snack bars.
Carrie Sens, RN, MSN President, California Society for Cardiac Rehabilitation	• We could hold health fairs at schools. • We need to recognize the value of school nurses and increase the number of school nurses. • We need more physical education classes.

Public Comments on Question #3a:

Community Member	Schools
Ann Miller, Dietetic Intern, Kaiser Permanente	• Develop education campaigns for school age kids. • Contests to make learning fun and rewarding!
Forrest L. Junod, MD, Medical Director, Sutter Heart Institute, Sutter Medical Center, Sacramento	• Strong messages in schools about nutrition and risk factors. • Physical education for schools • Continue aggressive non-smoking campaign. • Encourage schools to support programs of education as well as a real sense of health and safety.
Paul Akins, MD, PHD, Medical Director Mercy Stroke Center	• Obesity and inactivity have become epidemic in California. Education about how to determine ideal body weight, choose healthy foods, and seek help about weight loss are truly becoming an emergency item • Basic knowledge about vascular disease and how this can lead to damaged hearts and brains will help to reinforce the message.

3b. What needs to happen in California WORKPLACES to prevent heart disease and stroke?

Panelist	Workplaces
Amparo Villablanca, MD Associate Professor of Internal Medicine, Division of Cardiovascular Medicine, UC Davis Medical Center	• Use the workplace setting for education and prevention. • Eliminate unhealthy foods (meals, vending machines) from these settings nutritious meals.
John Yao, MD, MPH, MBA, MPA, FACP Senior Medical Director Blue Shield of California [written comments]	• Healthy, nutritious meals should be available in work environments. • There should be organized programs in the workplace to encourage exercise and other activities: for example, on-site fitness rooms, weight-reduction menu items in the cafeteria, etc.
John A. Bissell, MD Chief of Neurology Kaiser Permanente South Sacramento	• Kaiser as a workplace banned smoking ten years ago. This reduced smoking tremendously in our workers.
Carrie Sens, RN, MSN President, California Society for Cardiac Rehabilitation	• In the workplace we need to bring back brown bag lunches. • Partnerships could be developed between workplaces and hospitals, grocery stores, etc. • We should encourage exercise in the workplace.
Cathy L. Rasmusson, MHA Principal Consultant Healthy Business Designs, LLC	• The workplace is a captive audience. It is the place we spend most of our waking hours. It should be a key part of a healthy lifestyle. • Do we need to take a break? Are nutritious foods available? • Workplaces have to make environmental changes. Is there a place to walk? We need to help people take a break, make vending machines healthier. These are not dramatic changes.

Public Comments on Question #3b:

Community Member	Workplaces
Ann Miller, Dietetic Intern, Kaiser Permanente	• Education campaigns also n the workplace. • Again, contests to make learning fun and rewarding! • Some of the best outcomes come from challenging people and making it competitive, but fun.

Community Member	Workplaces
Forrest L. Junod, MD, Medical Director Sutter Heart Institute, Sutter Medical Center, Sacramento	• Strong messages at work about nutrition and risk factors. • Physical education for workers. • Encourage employers to support programs of education as well as a real sense of health and safety.
Paul Akins, MD, PHD, Medical Director Mercy Stroke Center	• Working adults are at a higher risk of developing hypertension, diabetes, elevated cholesterol, obesity complications and smoking related diseases. These can lead to premature vascular disease. Aggressive education campaigns on behalf of employers and unions would be helpful to keep a healthy work force. • Recognition of heart and stroke symptoms is also important.

3c. What needs to happen in California COMMUNITIES to prevent heart disease and stroke?

Panelist	Communities
Amparo Villablanca, MD Associate Professor of Internal Medicine, Division of Cardiovascular Medicine, UC Davis Medical Center	• Use communities and community clinics as prevention sites.
Dianne Hyson, PhD, MS, RD Assistant Professor, Adjunct Clinical Faculty, California State University, Sacramento	• Heart Smart Cities is a strategy we can utilize. • We should do community-wide education, walk-a-cop information, maybe a scavenger hunt in grocery stores. • A third of all meals are eaten outside the home. Often restaurants are willing to work with us to provide healthier meals to their clientele.
John A. Bissell, MD Chief of Neurology Kaiser Permanente South Sacramento	• Doctors need to aggressively treat obesity. When they tell their patient to quit smoking it makes the patient angry and upset, but 85 to 95 percent will try to quit. The same strategy needs to be applied to obesity and hypertension. • In regard to civil rights for fat people: obesity will cost all of us a lot of money. Fat people die and die prematurely. • We say everyone gets the same care but this is not true. We can't provide the same care. Some equipment can't work for obese people.
Carrie Sens, RN, MSN President, California Society for Cardiac Rehabilitation	• We need walking programs, and to develop more farmers' markets.

Public Comments on Question #3c:

Community Member	Communities
Deirdre Wentworth Program Manager Mercy Stroke Center	• The community, as a whole, needs to be committed to heart and stroke health. Where are the leaders and the media? • Children are not moving. They are sitting in front of TVs and computers. We need to start with the children. But we can do this when they are in schools. What happens when they go home? • The prevention of heart disease and stroke will not be with a designer drug. TV does great education of fast food and designer drugs. • We have to do this through healthcare organizations but also service clubs and media. • When you turn on America On Line, there are advertisements for the new designer drugs. What about information about the risk of heart disease and stroke?
Forrest L. Junod, MD, Medical Director, Sutter Heart Institute Sutter Medical Center, Sacramento	• Strong messages in communities about nutrition and risk factors. • The cost for obesity should be borne by those who are obese.
Paul Akins, MD, PHD, Medical Director Mercy Stroke Center	• Health education and coordination of EMS and hospital services regionally are the biggest issues facing communities. • We conducted numerous community stroke screenings and found that the information obtained by attendees was only briefly retained. We concluded that these "stand alone" events were probably ineffective unless they could be directly linked to the patient's doctors to trigger a more direct action. • Referenced article: How Effective are "Community" Stroke Screening Programs at Improving Stroke Knowledge and Prevention Practices? Results of a 3-Month follow-up Study. DeLemos, CD, et. al. *Stroke*, 2003 Dec;34(12):247-9.

4. What needs to change in the healthcare setting to improve a) prevention of heart disease and stroke, and b) quality of treatment delivered to patients with heart disease or stroke?

Panelist	Prevention	Quality of Treatment
Michael L. Carl, MD, FACEP Chief, Emergency Services Kaiser Permanente, South Sacramento	[verbal comments] • We need money spent on prevention. Focusing finances on treatment is a waste of resources. Prevention is our biggest pay off. • Funding prevention falls on all of us, in our personal lives, our homes, our votes. We need to get the funding we need for education and healthcare.	• [written comments] • We should have a strong commitment by the healthcare delivery systems and state and local governments to reduce emergency department and nursing shortages. [verbal comments] • We need to coordinate care. We need a strong commitment by the healthcare delivery system and the state to reduce emergency room crowding. Time is of the essence and when we are overcrowded in emergency rooms, ambulances are diverted, there are not enough nurses, and we are not serving patients. • We need better integration between acute care, chronic disease management, and health education efforts.
John Yao, MD, MPH, MBA, MPA, FACP Senior Medical Director Blue Shield of California [written comments]	• Patient education should be provided with an emphasis on primary prevention. • We should have high-intensity disease management (for greater public health impact) and case management.	• We should have incentive programs for better management of health and outcomes (with health plan members, providers, etc.)
Cheryl Phillips, MD, AGSF, CMD Director, Sutter	• Doctors deal with episodic events and not the person's total health.	• We need to look to true chronic disease models. We need the

Panelist	Prevention	Quality of Treatment
Medical group Sacramento	• Our biggest barrier is access.	development of population registries with built in tracking and modeling. The registries would show how many have had various blood tests and link the information to evidence-based guidelines. • In sites of care, we need to coordinate goals of treatment. We don't do transitions of care well. We need to coordinate services on the acute side.

Public Comments on Question #4:

Community Member	Prevention	Quality of Treatment
Ann Miller, Dietetic Intern, Kaiser Permanente	• Education for physicians, nurses and patients, preferably in prevention.	• Staffing.
Forrest L. Junod, MD Medical Director Sutter Heart Institute Sutter Medical Center, Sacramento	• Improved recognition of signs and symptoms. • Tools to help screen through risk factors, finding what leads to heart disease.	• Guidelines for treatment and secondary prevention. • Evaluate methods of treatment. Satisfactory outcomes studies must be ongoing.
Paul Akins, MD, PHD Medical Director Mercy Stroke Center		• As a stroke director, I can tell you that our treatments for stroke are very primitive and rely mainly on supportive care and the natural regenerative properties of the brain. Major breakthroughs in reducing brain injury and improving outcomes are badly needed.

Community Member	Prevention	Quality of Treatment
Paul Akins, MD, PHD (cont'd)		• It is clear that there are substantial gains to be had with primary and secondary stroke prevention using current knowledge, but hat many patients with major risk factors are poorly managed for a variety of reasons. • I would like to see strong support of stroke centers working to advance stroke research and treatments. This will probably require a regional EMS triage system diverting acute stroke patients to stroke centers (similar to the Canadian system). • I would like to see increasing emphasis placed on aggressive risk factor management by primary care.

5. How can we reduce health disparities in heart disease and stroke?

Panelist	Opportunities to Reduce Disparities
Amparo Villablanca, MD Chair, Sacramento Public Forum Associate Professor of Internal Medicine, Division of Cardiovascular Medicine, UC Davis Medical Center, Associate Director of Women's Center for Health, UC Davis School of Medicine [written comments]	• We need to increase access by using appropriate languages. • We need appropriate educational materials that are appropriate culturally, linguistically, and geared to the right reading level. • Depression, isolation, and socioeconomic status require further analysis for their roles in heart disease and stroke. • Women as well as ethnic groups must be identified as an underserved group with health disparities. • We need to recognize the impact of depression, socioeconomic status, and social isolation on health disparities

Panelist	Opportunities to Reduce Disparities
Amparo Villablanca, MD (cont'd)	disparities. • We should use stories and cultural icons to deliver the prevention message. (Sona La Rona after-school program in NYC is an example.) • We should mandate that healthcare data on women be reported by gender. [verbal comments] • When we talk about health disparities, we are talking about the "have and have nots," including gender, ethnicity, attitudes, and cultures. Some cultures have fatalistic views, taboos. • We need to research underserved groups and identify disparities and the "whys" of disparities to lead us to appropriate strategies. • There are studies pointing to looking at different languages and reading levels that should be culturally appropriate. • Using stories and cultural icons can be an appropriate strategy. Pfizer is using storytelling and cultural icons, for example, with the Hispanic population in New York City. There is evidence that this is very effective. • The reporting of data is not mandated in ethnic and gender-specific ways. Minorities and women were mandated to be included in research but reporting of the data was not mandated. • There will be a tipping point; a state where people feel they can't tolerate things or the actions will have consequences. Evidence has changed and we are experiencing the beginning of a shift.
Michael L. Carl, MD, FACEP Chief, Emergency Services Kaiser Permanente, South Sacramento [written comments]	• Target the highest risk populations with the initial efforts, and provide a basic safety-net of healthcare for the under and uninsured, and low-income segments of the population. • Large portions of our state population are currently without a primary care physician and have no access to regular healthcare. Low-income patients often can't afford much needed medications for control of diabetes and hypertension. • Lack of education deprives them of the knowledge of the significant role that tobacco abuse has in the development of heart disease and stroke, and the knowledge of the morbidity and mortality caused by these two diseases.

Panelist	Opportunities to Reduce Disparities
Michael L. Carl, MD, FACEP (cont'd)	[verbal comments] • There are great disparities in our state. • It is a travesty that there are people in California with no or little access to healthcare. • A safety-net is needed. Now it is the emergency rooms in the state. • We should target high-risk populations with our initial efforts in regard to hypertension, diabetes, African Americans and Hispanics. • We run into caring for patients with no primary healthcare in the emergency room. They come in with an acute problem and there is nothing out there to funnel them to- any state healthcare system.
John Yao, MD, MPH, MBA, MPA, FACP Senior Medical Director Blue Shield of California [written comments]	• We must address education in affected population groups, which is the most important element in addressing health disparities. • We need to have access to healthcare for the uninsured. • We need culturally appropriate community outreach programs. • People's social-economic and educational status needs to be taken into account and its effect on health disparities. [verbal comments] • The more educated a population of people is, the better they tend to take care of themselves. • We need to consider how to address minority groups and disadvantaged populations.
Cathy L. Rasmusson, MHA Principal Consultant Healthy Business Designs, LLC	• Patients need to be funneled to resources. • We need to change the quality of healthcare itself. How can we use incentives for building in prevention? • We should utilize the five-a-day program, the American Heart Association, the American Diabetes Association, and funnel people into these programs.

Panelist	Opportunities to Reduce Disparities
Cheryl Phillips, MD, AGSF, CMD Director, Sutter Medical Group Sacramento	• We need to identify ethno-social cultural barriers. • Another disparity we have is that we have a "one-size-fits-all" healthcare system. We need to look at our primary care systems. • We need to shift to patient-centered care, shift our thinking from "non-compliant" to "non-agreement," and look at what gets in the way. • Disease recognition is important; people also need to understand our healthcare system.
Allan Siefkin, MD Executive Director, UC Davis Medical Group, Professor of Medicine, Associate Dean, UC Davis Medical Center	• There is disparity that occurs with access; there is variance in the type of care provided. • We should be building registries. We need evidence-based guidelines; we are getting there. Disparities will change with the implementation of evidence-based guidelines. • There are other disparities; not just uninsured but underinsured. We are dealing with them in our emergency rooms. • We have created a financing model for Medi-Cal that is the worst in the nation. • We need some form of universal coverage, not just single-payer; that has to be fixed. But we will have to have such pain to change. When there is enough pain, blood in the streets, there will be a political solution. There is not enough pain in America currently to make change. We will get political and policy solutions when that happens. • Healthcare financing and how to fix it; this could be debated forever but it will affect how we will get there because competing initiatives will take our dollars.
Mary Wieg, MBA, RN CalPERS Office of Health Policy and Plan Administration	• We could save fifty-percent of the cost of disease if we focused on prevention. If we can motivate people to change we won't need healthcare. • People need to make some hard personal choices and as a society we will all need to change.
Carrie Sens, RN, MSN President, California Society for Cardiac Rehabilitation	• We need to start early in school with healthy food, physical education, and no smoking. • Health professionals need to go into schools to teach heart awareness and utilize the AHA program. • We should establish health fairs and link hospital clinics with the schools. • Mental health issues need to be addressed and depression identified. • Outreach to communities, including religious communities needs to occur.

Public Comments on Question #5:

Community Member	Opportunities to Reduce Disparities
Ann Miller, Dietetic Intern, Kaiser Permanente	• Better healthcare. • More quality with health coverage.
Forrest L. Junod, MD Medical Director Sutter Heart Institute Sutter Medical Center, Sacramento	• Educate women about their risk and also the various ethnic groups about their specific types of risks. • Recognize uninsured and underinsured burden on the public because of delay in treatment and preventive health measures.
Paul Akins, MD, PHD Medical Director Mercy Stroke Center	• The reduction of disparities in heart disease and stroke is complex. Regarding stroke, socioeconomic status and ethnicity both play roles. In California, I have found that language and culture produce additional complexities; for example, I have personally encountered a high incidence of cerebral hemorrhage in the Hmong immigrant population in Sacramento. Education and mentoring of influential members within these communities will be important. • However, some of these differences likely reflect true differences in ethnic susceptibility to certain diseases; for example, the higher rate of cerebral hemorrhage in Asian populations, as compared to Caucasian populations.

Panelists' Open Microphone Comments

Panelist	Comments
Dianne Hyson, PhD, MS, RD Assistant Professor/Adjunct Clinical Faculty, California State University, Sacramento	• We need to focus on something people will do. There are a lot of times when there is a disconnect between the great ideas a group can come up with and what people will actually do. As we work with people we have to change our strategies.
John A. Bissell, MD Chief of Neurology Kaiser Permanente South Sacramento	• Heart disease and stroke are a modern phenomenon. These are the results of looking at a society that isn't moving physically.
Carrie Sens, RN, MSN President, California Society for Cardiac Rehabilitation	• People need to get angry about heart disease. Now people are treating heart disease and stroke like a rite of passage but too many people under 50 have cardiovascular disease.

UC Davis Medical Center Physicians and Researchers Answer Questions About Heart Disease and Stroke

Speakers

Amparo Villablanca, MD
Chair, Sacramento Public Forum
Associate Professor of Internal Medicine, Division of Cardiovascular Medicine, UC Davis Medical Center,

Director of the Women's Cardiovascular Health Program and Clinic, Associate Director of Women's Center for Health, UC Davis School of Medicine

Reginald Low, MD
Professor of Internal Medicine, Chief
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John Rutledge, MD
Professor and Chief
Division of Endocrinology, Clinical Nutrition and Vascular Medicine
UC Davis Medical Center

Jim Nuovo, MD
Professor, Department of Family and Community Medicine
UC Davis Medical Center

Jonathan Hartman, MD, Assistant Professor
Department of Radiology
UC Davis Medical Center

Lars Berglund, MD, Professor
Division of Endocrinology, Clinical Nutrition and Vascular Medicine
UC Davis Medical Center

Marc Schenker, MD, MPH
Professor and Chair
Department of Epidemiology and Preventive Medicine, UC Davis Medical Center

Piero Verro, MD, Assistant Professor
Department of Neurology
UC Davis Medical Center

Richard Kravitz, MD
Professor and Director
Center for Health Services Research in Primary Care
UC Davis Medical Center

1. What are the three most important changes in California that need to be made in order to reduce death and disability from heart disease and stroke?

Speaker	Most Important Changes to Be Made
Jonathan Hartman, MD Assistant Professor Department of Radiology UC Davis Medical Center	• Emphasize primary prevention and reduction of risk factors. • People should know their risk factors. • Obesity is epidemic.
John Rutledge, MD Professor and Chief Division of Endocrinology, Clinical Nutrition and Vascular Medicine UC Davis Medical Center	• Improve lifestyle management especially as it relates to diabetes and obesity. • Focus on high-risk groups, e.g., on African Americans, who are at high-risk for hypertension and on Latinos, who have a high prevalence of diabetes. • Find psychological approaches that will help people change their lifestyles.
Jim Nuovo, MD Professor Department of Family and Community Medicine UC Davis Medical Center	• Improve access to care. • Monitor outcomes and interventions to see what works.
Lars Berglund, MD Professor Division of Endocrinology, Clinical Nutrition and Vascular Medicine UC Davis Medical Center	• Make individuals stakeholders in their own healthcare.
Marc Schenker, MD, MPH Professor and Chair Department of Epidemiology and Preventive Medicine UC Davis Medical Center	• We need a broad-based community approach to reducing cardiovascular disease, and not necessarily only for those who are high-risk. • Must continue to emphasize primary prevention (per tobacco control model). • Create a heart-healthy environment.
Reginald Low, MD Professor of Internal Medicine and Chief Division of Cardiovascular Medicine UC Davis Medical Center	• Increase access and affordability of care. "Access" means having insurance and the ability to have medications. Increase affordability of medications (pharmacy costs have increased to twice the Consumer Price Index; 15-20% of people who can afford their meds, don't fill their prescriptions; 50% of those without insurance fail to fill their prescriptions).
Richard Kravitz, MD Professor and Director Center for Health Services Research in Primary Care	• Improve primary prevention—use social marketing to address nutrition and obesity. • Improve secondary prevention – identify and treat risk factors.

Speaker	Most Important Changes to Be Made
Richard Kravitz, MD (cont'd)	• Improve tertiary prevention – improve access to new technology.

2. What do people in California need to learn about heart disease and stroke? What do physicians and healthcare professionals need to learn about heart disease and stroke?

Speaker	Californians
Piero Verro, MD Assistant Professor Department of Neurology UC Davis Medical Center	• Must know their risk factors (according to Dr. Verro's survey of inpatients, 50% didn't know risk factors for stroke).
Lars Berglund, MD Professor Division of Endocrinology, Clinical Nutrition and Vascular Medicine UC Davis Medical Center	• Must have people understand that heart disease is preventable.
Marc Schenker, MD, MPH Professor and Chair Department of Epidemiology and Preventive Medicine UC Davis Medical Center	• Must denormalize the unhealthy lifestyle; need social marketing to change the norm. • Knowledge of what is unhealthy is necessary, but not sufficient.
Richard Kravitz, MD Professor and Director Center for Health Services Research in Primary Care UC Davis Medical Center	• Though some people are at higher risk for cardiovascular disease than others, everyone is at risk. • Link risk factors to cardiovascular disease (e.g., obesity).

3. What needs to happen in California schools, workplaces, and communities to prevent heart disease and stroke?

3a. What needs to happen in California SCHOOLS to prevent heart disease and stroke?

Speaker	Main points
John Rutledge, MD Professor and Chief Division of Endocrinology, Clinical John Rutledge, MD Nutrition and Vascular Medicine	• Bring back physical education.

Speaker	Main points
Marc Schenker, MD, MPH Professor and Chair Department of Epidemiology and Preventive Medicine UC Davis Medical Center	• Educate parents through their children. Look at the success that tobacco education has had.
Lars Berglund, MD Professor Division of Endocrinology, Clinical Nutrition and Vascular Medicine UC Davis Medical Center	• Provide healthy menus in the school setting and do not accept between-meal eating. Also, eliminate vending machines.
Richard Kravitz, MD Professor and Director Center for Health Services Research in Primary Care UC Davis Medical Center	• Address “over-nutrition” and “mis-nutrition.” Use revised food products and talk about why changes are being made.
Jonathan Hartman, MD Assistant Professor Department of Radiology UC Davis Medical Center	• Begin comprehensive education about nutrition and physical activity.
Reginald Low, MD Professor of Internal Medicine and Chief Division of Cardiovascular Medicine UC Davis Medical Center	• Mandate physical education. • Mandate health education classes. Add health questions to the high school exit exam.

3b. What needs to happen in California WORKPLACES to prevent heart disease and stroke?

Speaker	Workplaces
Marc Schenker, MD, MPH Professor and Chair Department of Epidemiology and Preventive Medicine	• Educate employees in the workplace – it will become a win/win for employees and employers.

3c. What needs to happen in COMMUNITIES to prevent heart disease and stroke?

Speaker	Communities
Marc Schenker, MD, MPH Professor and Chair Department of Epidemiology and Preventive Medicine	• Promote non-motorized transportation.
Richard Kravitz, MD Professor and Director Center for Health Services Research in Primary Care	• Link risk factors to cardiovascular disease, not simply poor health.
Piero Verro, MD Assistant Professor Department of Neurology	• We are swimming upstream against the fast food industry.

4. What needs to change in the healthcare setting to improve a) prevention of heart disease and stroke, and b) quality of treatment delivered to patients with heart disease or stroke?

Speaker	Prevention	Quality of Treatment
Jim Nuovo, MD Professor, Department of Family and Community Medicine	• Reimbursement must support education and prevention.	
John Rutledge, MD Professor and Chief Division of Endocrinology, Clinical Nutrition and Vascular Medicine	• Improve access.	

Speaker	Prevention	Quality of Treatment
Piero Verro, MD Assistant Professor Department of Neurology UC Davis Medical Center		• Define goals within a setting; establish benchmarks for assessing performance and outcomes.
Marc Schenker, MD, MPH Professor and Chair Department of Epidemiology and Preventive Medicine	• Benchmarks for prevention should be established and supported by reimbursement.	
John Rutledge, MD Professor and Chief Division of Endocrinology, Clinical Nutrition and Vascular Medicine	• People need to be motivated to address health problems that are not causing pain or other noticeable symptoms.	
Jonathan Hartman, MD Assistant Professor Department of Radiology UC Davis Medical Center	• All patients should have their cardiovascular disease risk profiled no matter what their reason is for seeing a provider; then those with high-risk should be plugged into a cardiovascular disease clinic.	
Lars Berglund, MD Professor Division of Endocrinology, Clinical Nutrition and Vascular Medicine UC Davis Medical Center	• Insurance companies should require reports documenting preventive care.	• Use team approach in cardiovascular disease clinics; change laws and reimbursement to support this. • Use physician audits (or the threat of them) to improve quality of care.

5. How can we reduce health disparities in heart disease and stroke?

Speaker	Opportunities to Reduce Disparities
Jim Nuovo, MD Professor Department of Family and Community Medicine	• Improve access to care. • Consider using community-based interventions that have proved to be successful (e.g., promotoras).
Piero Verro, MD Assistant Professor Department of Neurology UC Davis Medical Center	• Educate these populations through culturally appropriate programs. • Add questions to the drivers' test regarding cardiovascular disease risk factors. • Incentivize patients to change their lifestyles through tax incentives, etc. • Provide easier access to medications.

Open Microphone Comments

Speaker	Comments
Marc Schenker, MD, MPH Professor and Chair Department of Epidemiology and Preventive Medicine UC Davis Medical Center	• Primary prevention should be the focus. • In the Hispanic population, smoking behavior increases after immigration. • We have to change population behaviors. • We need to focus on children.
Reginald Low, MD Professor of Internal Medicine and Chief Division of Cardiovascular Medicine UC Davis Medical Center	• We need a statewide media campaign on cardiovascular disease risk factors and how to reduce them. • Mainstream TV and movies should model behavior that is heart healthy. • Schools should be ambassadors of health.

Panelist's Biographies

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Dr. Bissell received his undergraduate degree from Stanford University in 1964 and his medical degree from Harvard University in 1969. He spent two years at the National Institutes of Health in Bethesda, Maryland, as a staff associate in virology from 1970-1972, and completed his residency in neurology at Harvard (Peter Bent Brigham, Beth Israel, and Children's Hospital in 1975. He has been a member of the Permanente Medical Group since July 1, 1975. He has been Chief of Neurology at the South Sacramento Kaiser Foundation Hospital since 1984 and is a Fellow of the American Academy of Neurology.

Name:	Michael L. Carl, MD, FACEP
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Dr. Carl received his medical degree from the University of California, Davis in 1992. He completed residency in emergency medicine at the UC Davis Medical Center in 1995, having served as chief resident from 1994 to 1995.

Dr. Carl has been a staff emergency physician with Kaiser from 1995 to the present time, and chief of emergency services at the South Sacramento Medical Center since 2003. Areas of research interest and publication have involved pulmonary physiology, emergency jet ventilation, and ultrasound by emergency physicians. Dr. Carl also has strong interests in medical ethics, having served as chair of his hospital's bioethics Committee from 1999-2003.

Name:	Dianne Hyson, PhD, MS, RD
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Dianne Hyson PhD, MS, RD is an Assistant Professor of nutrition at California State University, Sacramento and an Adjunct Clinical Faculty member in Internal Medicine at the University of California, Davis. She has conducted studies and published research related to the relationship between dietary practices and heart disease risk factors both in the US and abroad. Her particular area of interest is the effect of postprandial lipemia (nonfasting lipid effects) on risk of chronic disease. She has worked with a number of commodity groups to examine the influence of various foods and components on markers of heart disease. Dr. Hyson was extensively involved in the development and operation of the Cardiac Rehabilitation and Coronary Heart Disease Reversal Programs at the University of California Davis Medical Center for many years and has been an active registered dietitian in the Sacramento region for 14 years.

Name:	Cheryl Phillips, MD, AGSF, CMD
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Cheryl Phillips, MD is the Medical Director of Sutter Medical Group, a 200-member multi-specialty group in Northern California. She is also the Regional Director for Skilled Nursing Services and Chronic Care in the Sutter Health Sacramento Sierra Region, and has served as the Medical Director for several freestanding skilled nursing facilities, including Sutter's hospital-based subacute unit in Sacramento. Her clinical practice is limited to frail elder care in the home, nursing home and hospital. She has developed a geriatric risk screening and care coordination program for high risk and frail elders enrolled in Sutter's Medicare HMO plans, and has linked this care coordination program to a "SNF" provider team of physicians and nurse practitioners that follow the Sutter Medical Group patients in the post-acute and long term care setting. She is the past-president of the American Medical Directors Association (AMDA) and has served on multiple national boards and advisory groups for chronic care; including Sutter Health VNA and Hospice; the National Chronic Care Consortium Executive Committee and the CMS Technical Expert Panel on Quality Indicators in Long Term Care. She is the geriatric education coordinator for the Sutter Family Practice residency program and directs a long-term care clinical tract for the resident physicians. In 2002, she served as one of 30 fellows

for the Primary Health Care Policy Fellowship under Secretary Tommy Thompson, Department of Health and Human Services. She has provided testimony to the U.S. Senate, Special Committee on Aging regarding integrating care for persons with Alzheimer's disease. She completed her family practice residency and geriatric fellowship at the University of California, Davis, where she currently holds a faculty appointment as Clinical Professor in the Department of Family Practice.

Name:	Cathy L. Rasmusson, BS, MHA
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Cathy is the Principal Consultant for Healthy Business Designs specializing in developing worksite health promotion programs that make a difference for employers, employees and health care costs. Previously, Cathy served as the Area Health Promotion Specialist for the California Diabetes Control program focusing on integration of diabetes care guidelines within medical care settings. Cathy has also worked for the California Tobacco Control Alliance and the American Heart Association. Cathy was the Corporate Wellness Coordinator for the American Heart Association and instrumental in the initial start up of the Sacramento Stroke Task Force. Cathy also coordinated the first "Women and Heart Disease" event in Sacramento. Cathy is honored to be part of the Senate Task Force on Youth and Workplace Wellness as well as a number of other organizations that influence healthy lifestyles.

Name:	Carrie Sens, RN, MSN
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Carrie Sens is a nurse and has worked in the field of Cardiology for 18 years. Ms. Sens began her career as a nurse caring for patients after bypass surgery, heart attacks and other various procedures. She moved into Cardiac Rehabilitation and found that she was able to use her degrees in nursing and physical education effectively. Upon completing her masters degree in nursing, she moved into the role of Cardiac Nurse Educator, where she teaches patients and their families about heart disease, activity guidelines, nutrition and prevention. Ms. Sens has been a member of California Society for Cardiac Rehabilitation (CSCR), the professional organization, for over 12 years working on various committees. She represented this professional organization to the Cardiovascular and Disease Prevention Coalition until it

disbanded. Currently, she has been the acting President for the organization and represents California to the national professional organization.

Name:	Selinda Shontz, RD
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Selinda Shontz is the Senior Director of Stroke Programs for the American Heart Association. Selinda, a registered dietitian, has worked in the public health arena for 25 years. Before working for the American Heart Association, Shontz worked as the Cardiac Nutrition Specialist at Mercy General Hospital. Having worked for the American Heart Association for 17 years, Shontz has been responsible for designing and implementing many of the organization's cardiac and stroke education programs. Her current responsibilities include working with pre-hospital personnel, hospitals and the community in all aspects of rapid recognition and response to stroke. In addition to coordinating stroke programs in the Sacramento area, Shontz also acts as a consultant for stroke programs across the American Heart Association's Western States Affiliate, which includes California, Nevada, and Utah.

Name:	Allan Siefkin
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Allan Siefkin is the Chief Medical Officer for the UC Davis Health System, Executive Director of the UCD Medical Group (700 faculty physicians and 700 residents), Associate Dean for Clinical Affairs for the UCD School of Medicine, and Medical Director for the University of California, Davis Medical Center. Dr. Siefkin is responsible for coordination of clinical activities between the physicians within the School Of Medicine and the Academic Medical Center including Medical Staff activities, Peer Review, Quality Activities, Licensure and Accreditation, Compliance Operations, Clinical Resource Allocation and Utilization. He is board certified in Internal Medicine, Pulmonary Medicine, and Critical Care Medicine and is an active clinician and teacher within the Medical Group and Medical School.

Name:	Amparo Villablanca, MD
Title:	Chair, Sacramento Public Forum, Associate Professor of Internal Medicine, Division of Cardiovascular Medicine at UC Davis Medical Center, Director of the Women's Cardiovascular Health Program and

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Amparo C. Villablanca is a physician-scientist with 13 years of experience in academic medicine in a large university medical center serving the primary and tertiary care needs of a major metropolitan region. She has extensive clinical experience in non-invasive cardiovascular clinical medicine and preventive cardiology with a focus on coronary heart disease and atherosclerosis
Dr. Villablanca earned a bachelor's degree of science in Psychobiology at the University of California, Los Angeles. She earned her medical degree from the University of California, Davis School of Medicine. Her residency was in Internal Medicine at the University of California, Davis. She was a Research Fellow with the NIH Interdisciplinary Clinical Research Fellowship and worked in the Bronchial Circulation and Vasoactive Peptides, Laboratory of Dr. Gibe Parsons with the University of California, Davis and was a Clinical Fellow in Cardiovascular Medicine with University of California, Davis. With recognized expertise in cardiovascular disease in women, women's health and women's health leadership, Dr. Villablanca is an educator for medical, post-graduate, and continuing medical education physician programs; formal coursework in teaching skills; experience with curricular and educational program development. Moreover, she has experience with grant writing, and execution and management of industry and federally funded research basic science and transnational research programs. In addition, Dr. Villablanca has training and experience in executive leadership in academic medicine with an emphasis on academic development to include diversity development, gender issues in medicine, cross-cultural medicine, mentoring and faculty development.

Name:	Mary Wieg, MBC, RN
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For the past three years, Mary has advised CalPERS on health care quality evaluation and improvement, preventive health, and disease management programs in the health plans serving CalPERS' 1.2 million members. She represents CalPERS in the California Cooperative Healthcare Reporting Initiative, and is responsible for writing CalPERS' annual Quality Report that is made available to members to assist them in choosing their health plan. Prior to her work with CalPERS, she worked for six years with the Department of Corporations, which became the Department of Managed Health Care, conducting surveys of health plans' health care delivery systems to

determine their compliance with the Knox-Keene Act. Mary holds a bachelor's degree of science degree in Nursing, and an MBA in Health Service Management

Name:	John Yao, MD, MPH, MBA, MPA, FACP
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Dr. Yao is a Fellow of the American College of Physicians is Board Certified in Internal Medicine. Currently, he is a Senior Medical Director with Blue Shield of California. His previous experience includes the following roles: Senior Medical Advisor, Department of Health and Human Services; Medical Director, CIGNA Health Care; Public Health Policy and Epidemiology; Clinical Practice in Emergency Medicine and Internal Medicine; and Assistant Clinical Professor at University of California, San Francisco Medical Center.

State and Local Contacts

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Sacramento Resources	
American Heart Association	(916) 446-6505
Mercy Heart Institute	1 (877)-9heart9 www.chwhealth.com/mercyheart/
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San Diego Public Forum on Heart Disease and Stroke Prevention and Treatment

Summary of Key Findings

Panelists and community members highlighted the magnitude of problems related to heart disease and stroke in San Diego and throughout the state of California and offered specific strategies to address these problems. This summary captures the key points presented by expert panelists and community members at the public forum held on March 25, 2004.

Specific Findings and Recommendations

QUESTION #1:
WHAT ARE THE THREE MOST IMPORTANT CHANGES IN CALIFORNIA THAT NEED TO BE MADE IN ORDER TO REDUCE DEATH AND DISABILITY FROM HEART DISEASE AND STROKE?

San Diego panelists are emphatic that lifestyle changes and controlling risk factors are critical to reducing death and disability from heart disease and stroke. They recognize that obesity, inactivity and smoking are at the core of the heart disease and stroke problem and that we need to change not just behaviors through education, but there is a corresponding need for environmental change to support new behavior.

- Promote population-based and preventive strategies.
- Promote disease prevention, healthful lifestyles, and health issues by encouraging the public to engage in increased activity and proper diet.
- Disseminate important prevention messages regarding cardiovascular disease, including information about uncontrolled risk factors.
- Reduce sedentary behavior and improve diet.
- Support routine physical activity in communities with new policies.
- Provide public access to defibrillators and CPR training in high schools.
- Support measures to eliminate tobacco products including assigning fees and fines to make it harder to smoke in front of others.

QUESTION #2:
WHAT DO PEOPLE IN CALIFORNIA NEED TO LEARN ABOUT HEART DISEASE AND STOKE? WHAT DO PHYSICIANS AND HEALTHCARE PROFESSIONALS NEED TO LEARN ABOUT HEART DISEASE AND STROKE?

The panelists concurred that patients need to take a more active role as health consumers and to know that heart disease and stroke are preventable. Physician and healthcare workers need to realize that all people cannot be treated the same. We need different strategies for different populations.

Californians

- Californians, age 40 and above, need to know their numbers---blood pressure, blood sugar, cholesterol and BMI.
- Learn stroke and heart attack symptoms and the importance of early interventions when experiencing symptoms.
- The program "Screening, Brief Intervention, and Referral" is proven to lower risky drinking behavior. Develop a similar program for heart disease.
- Provide information on regional hospitals that are qualified to deliver acute care for heart attack and stroke.

Healthcare Professionals

- Counsel patients, using very clear logic, similar to the breast cancer awareness program.
- Implement "Know your Numbers" campaign and with focus on different ethnicities and women.
- Learn about the public health system.
- Embed public health education in the medical school curriculum.
- Learn more about AHA's "Get With the Guidelines."

QUESTION #3
WHAT NEEDS TO HAPPEN IN CALIFORNIA SCHOOLS, WORKPLACES, AND COMMUNITIES TO PREVENT HEART DISEASE AND STROKE?

The San Diego panelists were determined that California *schools* need significant reform, from eliminating junk foods to investing in a wellness curriculum that starts in grade school and addresses type 2 diabetes, smoking, obesity and inactivity. They also believe that local *businesses* need to be part of the solution, since they pay the hefty health insurance and workman's compensation costs. The panelists point to *the community* as an entity that must make tobacco inaccessible; make parks, bike lanes and sidewalks available and safe for walking and other physical activity; and partner with public health to create effective regional approaches to cardiovascular disease.

Schools

- Offer healthful food choices and incorporate physical activity into each school day, as well as during after-school care.
- Support walk-to-school programs.
- Move vending machines out of schools.
- Teach about heart disease, stroke, and risk factors; integrated into the science curriculum.

Workplaces

- Encourage active breaks and after-work activity.
- Make healthy foods available.
- Make stairs accessible and well-lighted.

- Promote health education for their workers.

Communities
- Make healthful foods available in food stores and restaurants.
- Provide safe parks and recreational facilities.
- Collect a tobacco and soda tax, dedicated to paying for improved community facilities for physical activity.
- Provide public health voice on local urban planning committees.
- Improve EMS to reduce death and disability from heart disease and stroke.

QUESTION #4:
WHAT NEEDS TO CHANGE IN THE HEALTHCARE SETTING TO IMPROVE: A) PREVENTION OF HEART DISEASE AND STOKE, AND B) QUALITY OF TREATMENT DELIVERED TO PATIENTS WITH HEART DISEASE OR STROKE?

Prevention
San Diego expert panelists report that hospitals are weak in the areas of prevention and rehabilitation and identify major gaps in hospital care. They point to hospital system and healthcare industry changes that would improve prevention of future acute events.

- Develop systems for hospital medical departments, such as emergency departments, to better communicate with primary care clinics.
- Ensure that the healthcare system provides primary care backup for patients who are discharged from a hospital.
- Initiate counseling/education prior to hospital discharge.
- Assign case managers to patients who require frequent ambulance calls and/or clinic visits.
- Adopt the AHA's "Get With the Guidelines" to ensure quality improvement and to prevent future acute events.
- Support community-wide nutrition, physical activity, and smoking cessation, and a continuum of care that doesn't end at the clinic door.

Quality of Treatment
Panelists essentially agreed that the healthcare system is in need of reform and must become proactive, not just reactive.

- Design a new emergency system, similar to the trauma centers of the 1980s, that responds to myocardial infarctions (MI) and stroke during "the golden hour."
- Reduce the number of coronary heart deaths and increasing the level of knowledge about heart disease and stroke among the population aged 20 years and older by strengthening EMS and public health partnerships.
- Link prescription medication with lifestyle changes.
- Increase time spent by healthcare providers with patients and reimbursements for health education activities.

- Establish database. By collecting data and outcomes, gaps in the healthcare system can be identified.
- Form new partnerships between public health, emergency medical services, and hospitals to address Healthy People 2010 and reduce heart disease and stroke death and disability.

QUESTION #5:
HOW CAN WE REDUCE HEALTH DISPARITIES IN HEART DISEASE AND STROKE?

One of the San Diego panelists cautioned everyone to remember that people do not choose to be obese and to die prematurely and that things in our culture reinforce risky behavior and poor lifestyle choices. The panelists all agree that there needs to be more funding and a coalition of partners to make changes in the environment.

- Institute a statewide strategic plan and funding at the local level to address healthcare disparities via linguistically and culturally appropriate campaigns.
- Reduce disparities by focusing on primary and secondary prevention efforts in communities where the needs are greatest.
- Increase the number of clinics and healthcare venues that provide screening opportunities.
- Address issues of diverse communities with representatives from diverse populations.
- Recruit and train minority students to work on projects.
- Give patients prescriptions for diet and exercise and make them come back in three months to see how they have complied with the prescriptions for lifestyle changes.
- Form a partnership between the state and the AHA to create a statewide awareness and educational program to help the general population recognize the signs and symptoms of heart disease and stroke, as well as the role that risk factors plan in the development of cardiovascular disease.
- Involve the business community and the chambers of commerce in solving the problem of populations that are disproportionately affected by heart disease and stroke.

San Diego Heart Disease and Stroke Prevention Public Forum:
Tables with Panelists' and Public Comments

March 25, 2004, University of California San Diego Medical Center Auditorium, 200 West Arbor Drive, San Diego, CA 92103

Panelists:

Nancy Bowen, MD, MPH
Public Health Officer
County of San Diego
Health and Human Services

Molly Bowman, MA
Senior Advocacy Director
American Heart Association

James V. Dunford, MD, FACEP
Professor of Emergency Medicine
UC San Diego Medical Center
Director of Emergency Medical Services, City of San Diego

Barry H. Greenberg, MD
Cardiologist, Professor of Medicine and Director of the Heart Failure/Cardiac Transplantation Program
UC San Diego Medical Center

Marla Hollander, MPH, CHES
Director, Active Living Leadership
Adjunct Professor, San Diego State University

Christy Jackson, MD
Neurologist, Clinical Professor
UC San Diego Stroke Center

Kenneth Lee Jones, MD
Pediatrician
Professor and Chairman of Pediatrics
UC San Diego Children's Hospital

William D. Keen, MD, FACC
Cardiologist, Assistant Chief of Internal Medicine, Co-Director of Heart Failure Program, Southern California Kaiser Permanente Medical Group

Paul S. Phillips, MD
Cardiologist, Director Interventional Cardiology Services, Scripps Mercy

Jack Schim, MD
Neurologist, Neurology Center, Encinitas; President, Association of California Neurologists; Associate Clinical Professor of Neurology, UC San Diego Medical Center

M. Scott Willson, MD, MPH
Primary Care Physician, Point Loma Medical Office, Kaiser Permanente
Primary Care; Cardiovascular Arterial Disease Task Force Delegate for Primary Care Quality Improvement

Judith R. Yates
Vice President and Chief Operating Officer
Healthcare Association of San Diego and Imperial County

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- John Kurata, PhD, MPH, Acting Chief, California Heart Disease and Stroke Prevention Program
- Nan Pheatt, MPH, Secondary Prevention and Professional Education Manager, California Heart Disease and Stroke Prevention Program, California Department of Health Services
- Belma Gonzalez, Program Coordinator, Center for Collaborative Planning
- Heather Hutcheson, Program Coordinator, Center for Collaborative Planning
- Connie Chan Robison, Director, Center for Collaborative Planning

Number Attending
23 Audience Members
12 Panelists

Promotional Activities:
The Planning Committee for the forum forwarded the Save-the-Date flyer to local stakeholders. The Center for Collaborative Planning (CCP) sent press releases and Save-the-Date information to state representatives, county supervisors, and the American Heart Association. In addition, CCP sent press releases to local media outlets, including print, radio, and TV through Congress.org. Outlets reached include:

- La Prensa San Diego
- North County Times
- San Diego Daily Transcript
- San Diego Union-Tribune – article published April 7, 2004.
- KFMB (CBS-8)
- KGTV (ABC-10)
- KNSD (NBC 7/39)
- KOCT (Channel 18, 19)
- KPBS (PBS 15)
- XETV (Fox 6)
- KFMB 760 AM
- KPBS 89.5 FM (NPR)
- California Healthline-article published April 6, 2004.

1. What are the three most important changes in California that need to be made in order to reduce death and disability from heart disease and stroke?

Panelist	Most Important Changes to be Made
Marla Hollander, MPH, CHES Director, Active Living Leadership Adjunct Professor San Diego State University [written comments]	• Policymakers and health professionals need to focus and support disease prevention and healthful lifestyles strategies. This needs to happen as we continue to support healthcare (clinical models) strategies. • The two most important prevention strategies include reducing sedentary behavior and improving diet. Promotion of healthful diet and physical activity; engagement in both of these lifestyle behaviors have been shown to lower the risk for developing specific chronic diseases such as heart disease, stroke, diabetes, osteoporosis, and many types of cancer (CDC 1996). Poor diet and physical inactivity account for over 300,000 deaths every year, only second to deaths caused by tobacco use (Department of Health and Human Services, CDC, 2003). California residents have not escaped this epidemic of sedentary behavior related to diseases. In fact, 57% of Californians were estimated to be obese or overweight in 2001, slightly above the national average. About 69% of Californians were either completely inactive or getting insufficient activity in 2000. • Focus on creating healthful environments. It is incredibly difficult to change behavior, especially in the absence of a supportive environment. We need places, spaces, and policies that support routine physical activity, and access to fresh, healthful foods. Examples of how unhealthy our environments have gotten include: 10% of children are currently able to walk to school versus 80% just one generation ago. Adults who live in homes built before 1973 (older communities) are significantly more likely to walk than people who live in homes built after 1973. Between 1983 and 1990, vehicle miles traveled grew 42% while walking trips decreased by the same percentage. • Communities need to address food access issues such as the number of places where fresh fruits and vegetables are available in a community. Building supermarkets, adding farmers markets and community co-ops are all ways to increase the availability of healthful foods.

Panelist	Most Important Changes to be Made
Marla Hollander, MPH, CHES (cont'd)	• We need to partner with urban planners, public health professionals, and community leaders. The physical design of communities can be improved to facilitate more physical activity (i.e. adding sidewalks, playgrounds) using mixed-use design principles to give people destinations within walking distance of their homes. In addition, people must be able to access healthy foods. If there is limited access to healthful foods, individuals will find difficulty maintaining their healthy behaviors (Sallis, Bauman and Pratt, 1998]. [verbal comments] • Policymakers and healthcare professionals need to promote disease prevention, healthful lifestyles, and health issues by encouraging the public to engage in increased activity, proper diet. • People do not understand the importance of activity and diet in this country, even in California. Obesity in California is above the national average. • We need to change codes and zoning ordinances so kids can walk to school. • We should partner with professionals to dictate how places are designed: transportation specialists, urban planners, parks and recreation.
M. Scott Willson, MD, MPH Primary Care Physician Point Loma Medical Office Kaiser Permanente Primary Care Cardiovascular Arterial Disease Task Force Delegate for Primary Care Quality Improvement	• We need to create safe community environments that facilitate more walking. • There should be support for a statewide media program with information on risk reduction, benefits of aspirin, how to control diabetes, heart-smart foods. I am concerned that people in communities don't have this kind of information. • The state should support any and all measures to eliminate tobacco products including assigning fees and fines (to make it harder to smoke in front of others) and health insurance incentives for smoking cessation programs and medicines. • Health insurance should cover weight reduction and tobacco cessation programs.

Panelist	Most Important Changes to be Made
Molly Bowman, MA Senior Advocacy Director American Heart Association	• All strategies should be population-based and preventive. • Regarding the environment: we need to make it as easy to make healthful choices as unhealthful choices. • We should encourage the "village concept" with increased walking and access to healthful foods. • Children should be learning that people need to be active, how to eat well, and not smoking; schools should offer healthful foods and physical activity. • We need to make it easy to get preventive health screening and information.
James V. Dunford, MD, FACEP Professor of Emergency Medicine UC San Diego Medical Center Director of Emergency Medical Services City of San Diego	• California must provide better access to primary care to reduce cardiovascular disease. • As an emergency department physician, I have observed that the current model of cardiovascular disease management appears to be predominantly reactive rather than proactive. • Poorly controlled blood pressure, diabetes, smoking, and obesity are rampant in my patients. • Patients routinely state that their CVD conditions are no longer being treated due to lack of insurance. These people will one-day - quite predictably - be arriving in emergency departments on paramedic gurneys with crushing chest pain, or acute paralysis. Ironically, an uninsured carpenter with hypertension and diabetes usually has a harder time finding quality care than an incarcerated child abuser. • Commonly, patients will get treated for the crisis but then, their insurance will run out. • We need kids to be healthier. We should create wellness reality programs: "Reality 101." Like reality TV, people would see emphysema lungs, clogged arteries, etc. • There should be public access to defibrillators; CPR training should be required for high school graduation. Students would feel empowered at knowing they can save lives. This generates a culture of empowerment. • The community needs to come together as a whole to help support public health departments.
William D. Keen, MD, FACC Cardiologist, Assistant Chief of Internal Medicine	• Scare tactics don't work. So they won't work for the prevention of cardiovascular diseases—not sure the state wants to conduct a scare tactic campaign. • The state can conduct an education/advertising

Panelist	Most Important Changes to be Made
Co-Director of Heart Failure Program, Southern California Kaiser Permanente Medical Group	campaign designed to change the current culture: communicate idea that being overweight and inactive are not cool. • A lot can be done in schools and workplaces regarding nutrition and physical education. But trying to change the community to be like a village sounds lovely but is not something the state can do. • We should recognize health systems that are successful and use best practices.
Judith R. Yates Vice President and Chief Operating Officer Healthcare Association of San Diego and Imperial County	• We should emphasize prevention. • We need early intervention and start in the educational arena. • We need to educate people on the signs and symptoms; and have them partner with physicians. • Any community can impact standards of care. Quality of care is definable over time.
Kenneth Lee Jones, MD Pediatrician Professor and Chairman of Pediatrics UC San Diego Children's Hospital	• I am the only pediatrician on the panel and I'm delighted to hear my colleagues discussing early intervention. • There is a need for this realization: aging begins at conception. The infants of women with hyperglycemia are at-risk. Women with gestational diabetes have kids who are more likely to develop diabetes. • We need to stress the smoking prevention issue – it is extraordinarily important. • As we see increasing incidences of obesity, diabetes, and hyperglycemia, people will be coming into medical offices at an earlier age with cardiovascular events. • We've learned a lot about what causes cardiovascular disease and the causes of obesity. (Fat babies are at-risk for disease.) We need to impact base of information.
Barry H. Greenberg, MD Cardiologist, Professor of Medicine and Director of the Heart Failure/Cardiac Transplantation Program UC San Diego Medical Center	• The healthcare system is uniquely unsuited to do prevention; it is better at end-stage care. • Four heart hospitals have been built in Indianapolis (as reported in the New York Times); none of these hospitals has more than rudimentary prevention programs. • Reimbursement needs to be incentivized for prevention, not for end-stage care.

Public Comment on Question #1:

Community Member	Most Important Changes to be Made
Fran Brady Image & Health Consultant Total Look Concept	• I work in cardiopulmonary medicine. There are often downtimes when we are doing testing for the doctor. Can't we use this time for education? M. Scott Willson, MPH, MD, answered: • At Kaiser, no matter where the patient presents, that patient's chart has a label on it of any medical conditions. With a patient who has a significant medical illness, we're supposed to address that issue each time and anywhere they are seen in the system. • There is no reason education can't happen with every visit, including during mammograms, other tests, etc.
Anthony Orlando, Esq. Senior Policy Advisor County of San Diego	• Similar to the label on cigarettes, could we have a label for high fatty foods? William Keen, MD, FACC, answered: • There can't be warnings on fatty foods. It didn't work for cigarettes. • Scare tactics don't work. M. Scott Willson, MPH, MD, answered: • We can lower LDL through dietary means: and we can have labels that state heart smart/ heart healthy. Nancy Bowen, MD, MPH, answered: • If you know how to read food labels and can figure out, you would have information about healthy foods. But we need to make the labels more understandable to the general public. Christy Jackson, MD, answered: • We need to consider the time required to prepare fresh food and acquire fresh food. This is difficult on working parents.

2. What do people in California need to learn about heart disease and stroke? What do physicians and healthcare professionals need to learn about heart disease and stroke?

Panelist	Californians	Healthcare Professionals
Christy Jackson, MD Neurologist, Clinical Professor UC San Diego Stroke Center	• Know your numbers at age 40. Shouldn't we expect patients to know their last blood pressure number, blood sugar, cholesterol, BMI? • Stroke signs and symptoms information needs to be made available. People are likely to come in with symptoms of a heart attack because it hurts. With a stroke, they may experience numbness and will take a nap, and sleep through the 3-hour window in which intervention may be effective.	• Prevention is one of three things to focus on. • The patient seen today who was instructed on everything may still not be taking aspirin. • We need to take time to counsel patients, using very clear logic, similar to Breast Cancer Awareness programs. • With stroke: we must prevent disabilities. • If the MD discusses tobacco cessation (this is per the literature) for 1-3 minutes, the rate of tobacco cessation increases. • There should be a "Know Your Numbers" campaign, with information geared to different ethnicities, gender. • Information regarding who is most at-risk should be shared. (Women present with vague stroke symptoms. If MD's don't know this, how will people know the warning signs for strokes?) • There is no such thing as a <u>mild</u> heart attack or stroke. TIA is a warning sign <u>and</u> is a stroke.

Panelist	Californians	Healthcare Professionals
James V. Dunford, MD, FACEP Professor of Emergency Medicine UC San Diego Medical Center Director of Emergency Medical Services, City of San Diego	• Californians need to better understand their own risk for cardiovascular disease. They know that a steady diet of super-sized burgers carries higher risk, but they do not have a good sense of what their own risk is in relation to others. • I believe an annual scorecard that compared an individual's cardiovascular disease risk factors with their peers (same age group) would be an eye opener and an incentive for change. • Californians need to learn that it's never too late to start reversing the vascular damage caused by cardiovascular disease risk factors. • This campaign should be multi-media. Education can be focused during opportunities when people are especially receptive to learning. • A program entitled Screening, Brief Intervention and Referral (SBIR) is a proven tool to lower	• California's physicians need to learn a lot more about their public health system. Most physicians managing cardiovascular disease risk cannot name their public health officer or how to contact her or him, and probably have never heard of the Healthy People 2010 Objectives. • Public health education needs to become embedded in medical school curriculum. In 2001, the American Public Health Association and the Association of American Medical Colleges identified a need for such closer collaboration between medical schools and public health. • Local public health officials should also reach out to academic and other physician organizations to build stronger alliances. • California physicians need to learn more about existing tools and programs to reduce cardiovascular disease risk and assure quality care. • The AHA "Get with the Guidelines" program offers an excellent method of assuring that essential preventive cardiovascular disease measures are accomplished before patient discharge. • Physicians also need more opportunities to discuss community health issues such as cardiovascular disease in public meetings and forums.

Panelist	Californians	Healthcare Professionals
James V. Dunford, MD, FACEP (cont'd)	risky drinking behavior when applied in emergency departments and health clinics, and would likely be similarly valuable for addressing cardiovascular disease risky behavior. • Californians need to better understand the signs, symptoms, and time-critical aspect of stroke. Only a small percent of stroke patients arrive early enough to qualify for treatments that offer hope of full recovery. • The warning signs and symptoms of medical emergencies, and how to access emergency care should be taught in grade school. • Patients with risk for acute cardiovascular disease need to know which hospitals in their region are qualified to deliver care for heart attack and stroke. A new tool to assist patients and their providers is the JCAHO credentialing process for disease-specific care. To earn this	• Physicians need to know more about the epidemiology, resources, and cardiovascular disease outcome data in their communities. • To plan effectively, key stakeholders including Emergency Medical Services must have available hospital outcome data from cardiac arrest, such as a myocardial infarction and stroke registry, ensuring confidentiality. • Currently, Emergency Medical Services agencies cannot access the outcomes of cardiac arrest in their communities. A July 2003 USA Today series shined a spotlight on the lack of knowledge of cardiac arrest outcomes in the nation's major cities. • Systems are currently not in place to collect such HIPPA-sensitive data from hospitals, yet such data is essential to bettering the system. • Future regulation should assure that public health systems can successfully implement the internationally accepted Utstein cardiac arrest outcome reporting methodology. • Confidential heart attack and stroke registries are also essential to build stronger systems of cardiovascular disease care.

Panelist	Californians	Healthcare Professionals
James V. Dunford, MD, FACEP (cont'd)	distinction, facilities will have to demonstrate standardized methods for delivering clinical care based upon clinical guidelines and evidence-based practice and an organized approach to performance measurement. The state should vigorously support these efforts.	
Paul S. Phillips, MD Cardiologist, Director Interventional Cardiology Services, Scripps Mercy	• Why can't we each keep track of our own numbers? No one is taking part in their own healthcare and we should.	• Eighty percent of Medicare dollars will now be spent on end-of-life care, not on prevention. • "Get With the Guidelines" program tends to emphasize medications, not exercise, salt reduction, etc.
Jack Schim, MD Neurologist, Neurology Center, Encinitas; President, Association of California Neurologists Associate Clinical Professor of Neurology UC San Diego Medical Center		• We need to know the risk factors in the community to decrease what we have to manage. (We spend money on end-of-life, not on prevention.) • We need to know where risk factors fit in. It is clear we're ready to spend money down the line, but money for The Well Child Program is being decreased (and will cost us down the line.) We need to put money where it can count. • The healthcare system should be focused on intervention when an event has occurred. • We need a registry.

Panelist	Californians	Healthcare Professionals
Jack Schim, MD (cont'd)		• We need to try to get hospitals to understand the roles they play; not every hospital is able to have resources for all diseases. • We need to provide clear information on quality outcomes for cardiovascular diseases. • But we have no information/data on each doctor as to who can actually take care of particular diseases. (All doctors claim they can, but this isn't true.)
M. Scott Willson, MD, MPH Primary Care Physician, Point Loma Medical Office Kaiser Permanente Primary Care Cardiovascular Arterial Disease Task Force Delegate for Primary Care Quality Improvement	• We need to emphasize additive risks: obesity, diabetes, and look at these as total body diseases (they affect every organ). • We should speak of "arterial disease": because we have arteries from head to toe (that is, present the information in a broader way). • Don't forget about kidney damage.	
Kenneth Lee Jones, MD Pediatrician Professor and Chairman of Pediatrics UC San Diego Children's Hospital		• Cardiovascular disease is not completely preventable but we can delay and possibly prevent early events. • This is not like polio and other diseases. A very different kind of approach is needed. There will be no vaccine or magic bullet. • We have to address the fact that we can't treat all the people in the same way. We have diverse populations.

Panelist	Californians	Healthcare Professionals
Kenneth Lee Jones, MD (cont'd)		have diverse populations, races, ethnicities, and cultures. We need to communicate appropriately with different populations. • We can have the best techniques/therapies, but if we can't get people to recognize this is good, we won't be successful. • Need different techniques for different populations. The American Diabetes Association and the CDC recognize this and have different strategies. This is particularly true in California due to our diversity, so to be effective, we need different strategies.
Marla Hollander, MPH, CHES Director, Active Living Leadership Adjunct Professor, San Diego State University	• Californians need to learn and understand that heart disease and stroke are preventable, and that by incorporating healthful foods and physical activity into their lifestyle, they can decrease their chances for developing heart disease and stroke. • Women also need to hear more often that this is the number one killer of women today! • In part, our love of the suburban lifestyle and our car culture sometimes make it difficult for us to be healthy.	• Physicians and healthcare professionals need to learn that a focus on prevention today will stave off some disease tomorrow. • Most importantly, they can use their credibility as a trusted source to strongly encourage patients about the benefits of healthy eating and physical activity rather than focusing only on prescriptions (cholesterol lowering meds). • There are programs and supports out there that can help professionals. Physicians can connect to community-based programs that provide supports for lifestyle change as well as use current sound practice such as prescriptions for lifestyle behavior in addition to meds.

Panelist	Californians	Healthcare Professionals
Marla Hollander, MPH, CHES (cont'd)	• We may be the first generation of adults that outlive our children. Children for the first time ever, are experiencing type 2 diabetes. Diabetes at such a young age may mean earlier than usual onset of heart disease and stroke.	• Established researched programs like Prescription for Life (RX for physical activity), pedometer programs, the PACE project are easily available.

Public Comment on Question #2:

Community Member	Californians	Healthcare Professionals
Curley R. Jordan California Black Health Network		• Doctors and nurses suffer from the same health problems being discussed: obesity, lack of physical activity and yet, they expect patients to listen to their advice. • What are big hospitals or organizations doing about this? Jack Schim, MD, answered: • There are a lot of people who preach but don't live the message. Molly Bowman, MA, answered: • This can apply to policy makers. We need to educate everyone. Christy Jackson, MD, answered: • We had nurses that sent Krispy Kreme donuts to one of our stroke survivors. Nurses need education also.

Community Member	Californians	Healthcare Professionals
Curley R. Jordan (cont'd)		Paul S. Phillips, MD, answered: • We work within our own societies. For example, in some European countries you will find beer and wine in vending machines. • We will see in hospitals what we are seeing in society. We need to change the culture. We need health spas and gyms in hospitals and other workplaces for the employees.

3. What needs to happen in California schools, workplaces, and communities to prevent heart disease and stroke?

3a. What needs to happen in California SCHOOLS to prevent heart disease and stroke?

Panelist	Schools
Nancy Bowen, MD, MPH Public Health Officer County of San Diego Health and Human Services	• Schools should only offer healthful food choices. • Schools should incorporate physical activity everyday and into after-school care. • There should be an expansion of the numbers of students who can participate in team sports. • Schools should offer their P.E. facilities to the community.
Marla Hollander, MPH, CHES Director, Active Living Leadership Adjunct Professor, San Diego State University	• Only healthful items should be in school vending machines. • We should support Farm–to-School programs and salad bars. • Physical education at schools should be mandated and implemented every day of the week. • There should be support of walk-to-school programs. • We need to advocate reducing the acreage requirements for new schools so they can more easily be built in neighborhoods. • We need to support school nurses. [verbal comments] • We need to build schools in places that are healthy. • We need smaller schools, schools kids can walk to that

Panelist	Schools
Marla Hollander, MPH, CHES (cont'd)	are linked to parks, in neighborhoods. • We need to work with the State Education Department to not build new schools on the edges of communities.
Christy Jackson, MD Neurologist Clinical Professor UC San Diego Stroke Center	• Due to budget cuts in the schools, physical education has been cut along with art and music. Unlike art and music, physical education is not an enrichment class. We need it back for our children's health. • LA stopped having vending machines in schools. They may have more financial problems when they lose that revenue source.
James V. Dunford, MD, FACEP Professor of Emergency Medicine UC San Diego Medical Center Director of Emergency Medical Services City of San Diego [written comments]	• The AHA's "Heartsaver CPR in Schools" should be a requirement for graduation from California high schools (some countries require CPR training in order to obtain a driver's license). This course empowers young adults with the best current tools to save cardiac arrest victims, who, as often as not, will be a family member. • Partnerships with community healthcare providers and organizations should be developed. • There should be health camps to expose children to healthful living environments, away from second-hand smoke and fast food. These camps could teach healthful cooking and team sports. • We should encourage quality sports physical exams. • For children to grow up healthy, we must invest in an elementary school wellness curriculum. • Children face enormous obstacles and bad habits in their homes, from second hand smoking and poor eating habits and "couch potato" role models. There is nothing more depressing than caring for a Type 2 diabetic teenager who looks like the cookie cutter image of his obese parents. • Teachers should be infused with contemporary science to be qualified to teach healthcare, and there must be incentives for school boards to support curriculum reform. • Health class is not likely to be an Advanced Placement course but it should inspire children to enter healthcare careers.

Public Comments on Question #3a: None

3b. What needs to happen in California WORKPLACES to prevent heart disease and stroke?

Panelist	Workplaces
Nancy Bowen, MD, MPH Public Health Officer County of San Diego Health and Human Services	• There should be healthful foods available. • Active breaks and after-work activity should be encouraged. • Employers should provide health insurance that includes preventive care.
Marla Hollander, MPH, CHES Director, Active Living Leadership Adjunct Professor San Diego State University	• We need to demand that health insurance companies invest in prevention. • We should support incentives for using pedestrian oriented transportation. • There should be support for health programs, such as, pedometer challenges. • The stairs should be made accessible, are well lighted, and decorated. • There should be support for physical activity breaks and the provision of reimbursement for physical activities. • Build offices in walkable communities • We should force the market (and increase public demand) to look at where we put offices and create livable communities.
James V. Dunford, MD, FACEP Professor of Emergency Medicine UC San Diego Medical Center [written comments]	• Employers need to invest in their employees' health and wellness. • Health insurance should be provided with wellness benefits. • We should eliminate junk food in the workplace. • We should support emergency preparedness including access to 911, Cardiopulmonary Resuscitation (CPR), and Public Access to Defibrillation (PAD Programs).

<u>Public Comments on Question #3b:</u>

Community Member	Workplaces
Michael Nagy Policy Coordinator San Diego Regional Chamber of Commerce	• Large or small business can be an asset to promoting education. If they do not, they may have to pay more money for health insurance and workmen's compensation. • The business community wants to be part of the solution.

3c. What needs to happen in California COMMUNITIES to prevent heart disease and stroke?

Panelist	Communities
Nancy Bowen, MD, MPH Public Health Officer County of San Diego Health and Human Services	• Tobacco should be inaccessible. • We need to increase the number of school crossing guards. • We need to make our communities safe for walking and biking. • We need to make stairways more accessible. • Food stores and restaurants should have healthful food choices. • There should be safe parks and recreational facilities available for all people.
Molly Bowman, MA Senior Advocacy Director American Heart Association	• Smoking, physical inactivity and obesity lead to the number one causes of death. • Obesity costs us $14.2 billion per year in medical costs/lost employment and it's all preventable. • The amount of advertising on unhealthful foods and products and the amount tobacco companies spent on advertising nationally ($9.53 billion and $53 million in California). • We should increase the state's tobacco tax to pay for advertising and smoking cessation. • We need to match program to taxes. • We should propose a soda tax. We have to affect the marketplace and begin taxing snack foods that are high-caloric, non-nutritious foods. • Increase revenue to preserve our quality of life.
Marla Hollander, MPH, CHES Director, Active Living Leadership Adjunct Professor)	• There should be support investing in better urban planning, promoting mixed-use development projects that include pedestrian-oriented transportation options. • Supermarkets and farmers markets that sell fresh fruit and vegetables should be accessible, especially in low-income and disadvantaged communities. • We need venues and opportunities for physical activity (safe sidewalks, parks, and trails). • We should work with schools to ban fast-food restaurants and support farm-to-school programs instead. [verbal comments] • We should consider taxing fast foods. • There should be more taxes on cars.

Panelist	Communities
Kenneth Lee Jones, MD Pediatrician Professor and Chairman of Pediatrics UC San Diego Children's Hospital	• We need to encourage changes in the home about diet and physical activity. • There are some studies of children showing that it is hard trying to get them not to be sedentary because of video games and television. • Any time we allow our kids to sit and use only their thumbs; they are not doing something healthful. • If children want to watch TV, we should put a treadmill or exercise bike in the TV room. Or make a new rule: you pay for TV time—for every 10 minutes playing with friends or shooting baskets, they earn time toward their favorite TV show.
William D. Keen, MD, FACC Cardiologist, Assistant Chief of Internal Medicine, Co-Director of Heart Failure Program, Southern California Kaiser Permanente Medical Group	• Changing behavior is one of the most difficult things we can imagine doing. We can try to incentivize people but it is still very difficult. • Our instinct as humans is to eat and sit on the couch. • We are hunter-gatherers and are meant to conserve energy. • We are talking about changing our culture from being "fat and lazy" to being lean and active.
James V. Dunford, MD, FACEP Professor of Emergency Medicine UC San Diego Medical Center Director of Emergency Medical Services City of San Diego [written comments]	• Community leaders should partner with public health to create regional approaches to cardiovascular disease. • Public health should share ownership of processes and goals and solicit assistance of stakeholders including AHA, the business community, regional academic institutions, local healthcare associations, the medical society and professional organizations, political leaders, patients and victims, Emergency Medical Services, and public information officers • Examples of cardiovascular disease goals include (a) meeting the Healthy People 2010 cardiovascular objectives, (b) promoting community CPR and PAD programs; (c) reducing time to drug incatheterization laboratory for corrective procedures; (d) increasing the percentage of patients arriving within three hours of stroke onset; (e) increasing the percentage of patients who receive tPA within 3 hours of stroke onset..

Public Comments on Question #3c:

Community Member	Communities
Sylvia Wallace Media Relations Manager Kaiser Permanente Public Affairs, San Diego	• The Task Force of the San Diego Community Coalition concept has been very successful and has had a unifying effect. • There are a number of coalitions on different issues. We should adopt some of that best practice ideas, and we will see improvement in heart attacks and stroke prevention. We have had great success promoting flu shots and immunization. We need to apply this mentality to heart disease and stroke.
Anthony Orlando, Esq. Senior Policy Advisor County of San Diego	• Is there a public health voice on the urban planning and designing committee? Marla Hollander, MPH, CHES, answered: • A health professional sitting on the city planning board is an excellent idea. • Only 1% of planning boards across the nation have healthcare professionals. I don't know about the San Diego planning board. Nancy Bowen, MD, MPH, answered: • There are public health professionals working on urban planning: they are part of community input process.

4. What needs to change in the healthcare setting to improve a) prevention of heart disease and stroke, and b) quality of treatment delivered to patients with heart disease or stroke?

Panelist	Prevention	Quality of Treatment
Marla Hollander, MPH, CHES Director, Active Living Leadership Adjunct Professor San Diego State University (cont'd)	• The healthcare setting needs to be better connected to the community. Effective prevention of heart disease and stroke will only be accomplished if healthcare providers work with the community to help people understand why they need to take responsibility for their	• Physicians and healthcare providers need to realize the multitude of factors that lead up to a heart disease or stroke diagnosis, and that by taking a more holistic approach to treatment, the patient will respond better. • We need better linking of prescribing medications and healthy lifestyle behavior.

Panelist	Prevention	Quality of Treatment
Marla Hollander, MPH, CHES (cont'd)	diet and level of physical activity. • Support a continuum of care that does not end when a person walks out of the doctor's office. • Focus on the needs of older adults. How can the medical professional instill physical activity, good nutrition habits, and smoke-free habits? It's never too late to reap benefits from a healthful lifestyle and as our population continues to age, we need to focus on keeping them healthier longer. • Connect cardiovascular prevention efforts with prevention efforts for other chronic diseases. • The new state aging plan does a great job at incorporating the traditional medical model with promotion of healthful community design and lifestyle behavior. [verbal comments] • The heath care system is currently set up for critical care. • Older adults are a growing population. We have serious work in the next few decades. • We need to keep seniors healthy as long as possible.	

Panelist	Prevention	Quality of Treatment
Judith R. Yates Vice President and Chief Operating Officer, Healthcare Association of San Diego and Imperial County		• We need to look at what is happening outside the healthcare setting. We should look at healthcare in other settings of our lives. • We need a new healthcare system, one that is proactive not reactive. • We need to change the system, such as the time healthcare providers have with patients, as well as reimbursements—which services are getting reimbursed and by how much. • In terms of quality of care we can improve physician practice standards. • We should take discoveries from the laboratory to the bedside. • We need to increase standards of care. • We should reinforce and/or establish databases because we need to be driven by the numbers. • We need to identify gaps in care through the collection of numbers and outcomes information. • Healthcare should be community-based and we need to build confidence in our systems.

Panelist	Prevention	Quality of Treatment
Barry H. Greenberg, MD Cardiologist, Professor of Medicine and Director of the Heart Failure/Cardiac Transplantation Program UC San Diego Medical Center		• We should develop a system of recognition by the state of those hospitals and clinics that achieve excellence in various areas of prevention.
James V. Dunford, MD, FACEP Professor of Emergency Medicine UC San Diego Medical Center Director of Emergency Medical Services City of San Diego [written comments]	• Emergency departments and primary care clinics should strengthen their relationships to assure that patient follow-up for cardiovascular disease is consistently occurring. • Patients should have access to annual cardiovascular disease report cards that illustrate relative risk. • Patients should have access to simple pathways (including web-based) to reduce risk scores. • Providers should be given feedback on their success rates in referring patients for risk reduction strategies (e.g., smoking cessation, diabetic advice). • Hospital patients with cardiovascular disease risk should receive counseling before discharge. • Clinical case managers should be employed for patients requiring frequent ambulance or	• New partnerships between public health, Emergency Medical Services and hospitals need to evolve. • In 2001, the Emergency Medical Services - Public Health Roundtable identified many valuable synergies that would result from collaboration between Emergency Medical Services and public health. • American Public Health Association has also promoted closer relations with American Medical Association (AMA), American Association of Medical Colleges (AAMC) and CDC to build a stronger public health safety-net. • For example, closer Emergency Medical Services –Public Health partnerships would directly address several Healthy People 2010 cardiovascular disease objectives including: reducing coronary heart disease deaths and, increasing the proportion of adults aged 20 years and older who are aware of the

Panelist	Prevention	Quality of Treatment
James V. Dunford, MD, FACEP (cont'd)	clinic visits for cardiovascular disease - related conditions. • Hospital committees should prioritize cardiovascular disease quality improvement indicators, including use of tools such as "Get with the Guidelines." [verbal comments] • We need a better system to be assured that people get to primary care. • We should provide web-based information for patients and empower patient with tools they can access.	early warning symptoms and signs of heart attack as well as the importance of accessing rapid emergency care by calling 911. • In acute ischemic stroke and myocardial infarction, every minute of vessel blockage appears to contribute to a worse outcome. For heart attack, angioplasty is the preferred treatment while for stroke, tPA is beneficial if given within three hours of onset of symptoms. For both, the greatest good is provided with the earliest treatment. • New interventional approaches, hypothermia and other cytoprotective therapies offer hope to expand the therapeutic time window. • No hospital has such technology and capability 24/7/365; some parts of California entirely lack these resources. • Not all emergency medical service systems (currently including the City of San Diego) have the technology to identify heart attack victims and few communities have developed policies that direct ambulances with suspected stroke or heart attack to pre-designated facilities. Costly delays result when patients are transferred. • In a 2003 Task Force

Panelist	Prevention	Quality of Treatment
James V. Dunford, MD, FACEP (cont'd)		Report from the National Institute of Neurological Disorders and Stroke, communities are encouraged to review their existing plans for stroke so that the best immediately available resources can be provided for each patient's needs, in much they way we designed regional trauma systems in the 1980's. • Communities should choose whatever strategy works best for them, from the deployment of mobile stroke teams to telemedicine and regional referral to pre-identified facilities. • Strong leadership is required to implement reform. • The New York Department of Health, in partnership with the American Stroke Association, recently completed a "stroke center demonstration project" testing the hypothesis that the designation of stroke centers would improve the quality of care in Brooklyn and Queens. After training, 19 out of 32 hospitals met requirements of the Brain Attack Coalition. Preliminary results suggest improvements in important processes of care including shorter times to care, greater numbers of patients with stroke arriving at stroke centers, improved

Panelist	Prevention	Quality of Treatment
		collegiality, increased public interest and increased interest on the part of other hospitals. The final outcome of this trial will bear significantly on our State's Master Plan. • Both heart attack and stroke demonstrate exciting opportunities for providers and community leaders to partner with public health to reduce death and disability. [verbal comments] • With cardiovascular disease, time is critical: we should have choreographed events, processes in place (similar to what is done with a shooting victim). • Identify best resources before a health crisis occurs. The EMS should have the ability to react immediately. Any community can design the system they want to. Getting the patient to the resource or the resource to the patient is the most important thing. • Non-traditional players should be at the table to identity resources too.
Kenneth Lee Jones, MD Pediatrician Professor and Chairman of Pediatrics UC San Diego Children's Hospital	• We should identify high-risk patients, families, and populations. For example: Native American families. • If diabetes is in the family history, prevention needs to begin right away.	• We will soon have the ability to identify risks by genotype. Society, government and insurance can use this technology as helpful interventions, but not in a punitive way. We will have to manage technology wisely.

Panelist	Prevention	Quality of Treatment
Paul S. Phillips, MD Cardiologist, Director Interventional Cardiology Services Scripps Mercy	• Hospitals are not well funded for rehabilitation and prevention. We don't do as much prevention as we could, even following a crisis. • The patient stays only two to three days in the hospital—their cigarettes aren't even stale on their nightstands when they get out. • We need to consider the prognosis for a patient with heart attacks and ways to prevent future incidents. • We could have hospitals with a gym on the bottom floor and with rehab nurses available.	• A gunshot wound sent to a hospital can be dealt with (we have the routine down) and yet heart attacks kill more people than gunshot wounds. • We need to get organized as to where people are taken. Not all hospitals should have catheterization laboratories that are open all night.

Public Comment on Question #4:

Community Member	Prevention	Quality of Treatment
Fran Brady	• Cardiovascular disease prevention should be linked together with prenatal classes. • We could utilize Prop 10 commissions and funds.	

5. How can we reduce health disparities in heart disease and stroke?

Panelist	Opportunities to Reduce Disparities
Nancy Bowen, MD, MPH Public Health Officer County of San Diego, Health and Human Services	• We have so-called "high-risk" populations but we need to remember that people do not choose to be obese or die prematurely. There are things going on in our culture to reinforce bad behavior. • Community collaboratives have been funded to organize themselves and develop solutions for

Panelist	Opportunities to Reduce Disparities
Nancy Bowen, MD, MPH (cont'd)	themselves regarding lack of access to healthcare, lack of healthcare coverage appropriate for their communities. • We need linguistically and culturally appropriate campaigns. We need to ask: What about different cultures? What are avenues to get information to different cultures and whom do they listen to? • We need a statewide strategic plan and need funding at the local level to address healthcare disparities.
Marla Hollander, MPH, CHES Director, Active Living Leadership Adjunct Professor San Diego State University [written comments]	• Disparities can be reduced by focusing primary and secondary prevention efforts in communities that need the most improvement. • We need MORE FUNDING. • Build supermarkets and farmers markets in low-income areas, increasing access to healthy foods. • Improve the urban setting and increase the number of safe, walkable areas in low-income neighborhoods. • Increase the number of clinics and heath care venues that provide screening opportunities, especially for youth. [verbal comments] • Increase the amount of funding to programs that aim to improve the physical environment and promote nutrition and physical activity in low-income areas. • To address issues of different communities, we need more diversity in representatives. All the faces look the same on this panel.
James V. Dunford, MD, FACEP Professor of Emergency Medicine, UC San Diego Medical Center, Director of Emergency Medical Services City of San Diego	• Recruit and train minority students • Employ ombudsmen and community leaders who are "culturally competent." • Assure universal health coverage. • Develop and share measures or standards of care for disparities.

Public Comments on Question #5: None

Panelists' Open Microphone Comments

Panelist	Comments
William D. Keen, MD, FACC Cardiologist, Assistant Chief of Internal Medicine Co-Director of Heart Failure Program Southern California Kaiser Permanente Medical Group	• Kaiser does everything that we are talking about. We are incentivized to conduct prevention activities and programs and we are set up to take care of our population as a whole. We have an entire database of patients and this allows us to know what disease(s) patients have and treat them. Kaiser is a good model with a best practices approach. • We have centralized trauma but not heart or stroke treatment. But taking care of heart attack and strokes makes money. Trauma loses money. • When we see patients, we don't expect them to do what we tell them to do. So when I see a patient, I don't expect them to start a physical activity program or to stop smoking. We should expect change and write it as a prescription.
Christy Jackson, MD Neurologist, Clinical Professor UC San Diego Stroke Center	• We need to give patients prescriptions for diet and exercise. They should come back three months later to check in. If we expect them to do it, they will. • With regard to prevention, we need to educate children in schools. We could adopt one or two main programs and take a generation through schools. We should be creating a program for life.
James V. Dunford, MD, FACEP Professor of Emergency Medicine, UC San Diego Medical Center, Director of Emergency, Medical Services, City of San Diego	• There are excellent web-based prevention programs that can bring information into someone's home. • We need public access to defibrillators; they need to be as common and mandated as fire extinguishers. Sports clubs and gym owners are especially worried about liability. We should see that legislative reform occurs to minimize the liability issue regarding defibrillators.
Molly Bowman, MA Senior Advocacy Director American Heart Association	• Business community should become involved. They bear the high cost with employment loss. The business community here in San Diego is serving on the healthcare committee and serves as advocates. • We should work with the Chamber of Commerce regarding stress management, cholesterol screening and tobacco cessation and prevention efforts, etc. • People who are at ideal weight, eat good foods, and are not stressed, decrease their risk of injury on the job and decrease workers compensation costs.

Panelist	Comments
Barry H. Greenberg, MD Cardiologist, Professor of Medicine and Director of the Heart Failure/Cardiac Transplantation Program UC San Diego Medical Center	• There should be an emphasis on prevention. It is difficult to change lifelong patterns. • We need to urge the state to consider partnering with AHA on awareness and education programs to recognize early signs and symptoms of CVD. • We need to capitalize on AHA's programs to educate the public.
Marla Hollander, MPH, CHES Director, Active Living Leadership Adjunct Professor San Diego State University	• Partnering between the public health and medical communities should occur. • We need to be aware of social and cultural norms. For example, thirty years ago, it was noticed in France that babies were getting heavier. In 10 years, they changed the belief that "fatter babies are happier babies". • We need to link social norms regarding diet, exercise, etc., with the culture.
Nancy Bowen, MD, MPH Public Health Officer County of San Diego Health and Human Services	• I agree it may be human instinct to eat and conserve energy (as mentioned by a previous speaker), but if we think about small children, they love being active and eat only until they are full. • We could say unhealthful behaviors are the result of people making independent "lifestyle" choices. But people need good options around and available. • It shouldn't be difficult in stores or restaurants to figure out the nutritional information of these foods and reflect this information in the advertising images. • When we work across society, we can make sea changes. Look at tobacco or drinking and driving or seatbelts. The Surgeon General could place labels regarding obesity everywhere, get everyone involved and then making the right choices will become voluntary. • Make changes in the laws, in community awareness, and create buy-in options to help people to make healthy choices. • Conduct a huge public awareness campaign.
James V. Dunford, MD, FACEP, Professor of Emergency Medicine, UC San Diego Medical Center	• Humans evolved through the mechanism of "survival of the fittest" and were first hunters and gatherers. Genetic evolution and cultural development clash when the environment doesn't need the genes we have anymore.

Panelist's Biographies

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Dr. Bowen is the Public Health Officer for the County of San Diego. She has worked for the County Health Department since 1986 in a number of capacities. She is a specialist in Preventive Medicine and graduated from UCSD Medical School in 1978, and received a Masters in Public Health in 1982.

Name:	Molly Bowman, MA
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A native San Diegan, Molly is the American Heart Association's Senior Director of Public Advocacy, representing San Diego, Orange and Riverside Counties. Her experience in the public affairs arena includes serving as an associate with The Campaign Group, a political media-consulting firm, and as a Field Representative to former Congresswoman Lynn Schenk. As an advocacy director, Molly creates and implements public policy strategies at the local, state and federal levels of government. Her policy focus includes tobacco control, access to health care, nutrition and physical activity, strengthening the Chain of Survival for heart disease and stroke patients, and increasing federal and state funding for biomedical research.

Name:	James V. Dunford, MD, FACEP
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Dr. Dunford attended Columbia University, College of Physicians & Surgeons. He received training in Internal Medicine at UCSD Medical Center and Board Certification in Internal Medicine (1979) and Emergency Medicine (1984). Dr. Dunford is the founding faculty member of the Department of Emergency Medicine at UCSD Medical Center. Dr. Dunford's responsibilities include and have included: emergency medicine physician (1980-present), flight physician, Life Flight San Diego (1980-1986), founding director, UCSD emergency medicine residency training program, Medical Director, San Diego Fire Department (1986-present), and Medical Director, City of San Diego EMS (1997-present). His interests are: EMS and public health, acute cardiovascular disease care, and new EMS technology. Dr. Dunford is the president-elect governing board of the San Diego American Heart Association and Chair, City of San Diego Clean Needle Exchange Pilot Program. He also is a Medical Advisor to the San Diego Homeless Outreach Team and a Medical Advisor to the San Diego Serial Inebriate Program.

Name:	Barry H. Greenberg, MD
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Dr. Greenberg, a graduate of Brooklyn College and Upstate Medical Center completed clinical training in medicine at George Washington University Hospital and Yale-New Haven Hospital. Following further research training at the Lipid Metabolism Branch of the NHLBI and the Cardiovascular Research Institute at UCSF, he completed his cardiology fellowship at UCSF and joined the faculty of the Oregon Health Sciences University. Prior to arriving at his present position as Professor of Medicine and Director of the Heart Failure/Cardiac Transplantation Program University of California, San Diego, he was Visiting Professor in residence at both the Royal Postgraduate Medical School in London and the Laboratory of Experimental Medicine in Paris. Dr. Greenberg has long-standing interests in the basic cellular mechanisms and in the management of patients with heart failure and has published extensively in these areas. He serves on the executive steering committees of numerous national and international clinical trials in heart failure. He is Associate Editor of the Journal of the American College of Cardiology. Dr. Greenberg is a founding member and current Secretary of the Heart Failure Society of America (HFSA). He serves as Chair of the HFSA's Heart Failure Awareness Committee Program that is designed to improve patient understanding of heart failure and to educate primary care physicians about current and emerging approaches to heart failure treatment. Dr. Greenberg has been selected by his peers as one of the "Best Doctors in America" continuously since 1994.

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Marla Hollander has extensive experience in the areas of public health program development and management, strategic planning, social marketing, health communication, and philanthropy. She currently directs the *Active Living Leadership Initiative*, a national project working with state and local leaders to create more opportunities for active living in communities. Prior to her current role, she held an associate post at The Robert Wood Johnson Foundation. While at RWJF she worked in conjunction with a programming team to develop an active living grant portfolio in excess of $75 million dollars. Ms. Hollander has also held previous positions at the Centers for Disease Control and Prevention (CDC) and the American Cancer Society (ACS). As a fellow at the CDC Office of Health Communication, Ms. Hollander was responsible for investigating public perception of disease prevention and health promotion programming and assisting in developing a new organizational marketing brand for the CDC. As a fellow at the ACS she conducted formative research regarding evidence-based physical activity and nutrition programming. Prior positions included serving as project manager for a health communications firm where she was responsible for a variety of health related projects for such organizations as the National Institutes of Health, Howard Hughes Medical Institute, and the National Osteoporosis Foundation. Her primary areas of interest are focused in creating healthy, livable communities, social marketing strategies, and improving behavioral/lifestyle health issues. Ms. Hollander received her bachelor's degree in business management and marketing from Tulane University and her master's of public health in behavioral sciences and health education from the Rollins School of Public Health at Emory University.

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Dr. Christy Jackson is an associate professor of neurosciences and the director of stroke prevention at the UCSD Stroke Center. She also directs the UCSD Headache Clinic and the neurology core clerkship for the UCSD School of Medicine. Her most recent research has focused on stroke prevention using aspirin versus warfarin, as well as identifying patients who benefit from cholesterol reduction after stroke. Under her direction, UCSD's stroke prevention program has led the country in numerous stroke prevention trials. Dr. Jackson earned her medical degree and completed a residency in neurology, as well as an Internship in Internal Medicine at the University of Texas Medical Branch. She also completed a fellowship in cardiovascular disease at UCSD. Dr. Jackson is board certified in neurology and psychiatry and has received many outstanding teaching awards from the departments of neurosciences and family medicine at UCSD. Her work in the field of stroke has led to publications in the New England Journal of Medicine and Stroke.

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Dr. Kenneth Lee Jones attended Duke University School of Medicine where he earned his doctorate in medicine. He also attended Adelphi College in Garden City, New York and earned a bachelor's of arts degree in Chemistry, Magna Cum Laude. His recent positions include: Professor of Pediatrics and Chair in the Department of Pediatrics at the University of California, San Diego, School of Medicine and Physician-in-Chief at Children's Hospital of San Diego. In addition he has been a Professor of Pediatrics and Interim Chair in the Department of Pediatrics at the University of California, San Diego, School of Medicine, and Professor of Pediatrics, Chief, Division of Diabetes and Endocrinology at the University of California, San Diego, School of Medicine. His postgraduate training includes a Postdoctoral Fellowship with the University of California, San Diego Department of Biology, a Hospital Appointment with Union Memorial Hospital in Baltimore, Maryland, service as Resident and Chief Resident at The Johns Hopkins Hospital in Baltimore, Maryland, service as a Physician in the United States Army, and an internship with The Johns Hopkins Hospital. Dr. Jones is a Member of Alpha Omega Alpha, Society for Pediatric Research, Tissue Culture Association, Western Society for Pediatric Research, Lawson Wilkins Pediatric Endocrine Society, American Academy of Pediatrics-Fellow, American Academy of Pediatrics, Endocrine Section, American Diabetes Association, American Pediatric Society, and The Endocrine Society. An active community member, Dr. Jones' community service includes television appearances, speaking engagements, and

publications. In addition, Dr. Jones has been a member of numerous committees and has received special appointments. Among his awards and honors Dr. Jones has earned the Merck Award, a National Cancer Institute Special Fellowship, San Diego Press Club, Headliner of the Year Award in Medicine, and Outstanding Teacher Award.

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Dr. Keen attended medical school at the University of Medicine and Dentistry of New Jersey School of Medicine in Newark, NJ. His medical training includes an Internship with Beth Israel Hospital in Boston, MA, a Residency with Thomas Jefferson University Hospital in Philadelphia, PA and a Fellowship with Thomas Jefferson University Hospital in Philadelphia, PA. He has board certification in Cardiovascular Disease from the American Board of Internal Medicine. Dr. Keen joined Permanente Medical Group in 1997.

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Director of interventional Cardiology at Scripps Mercy since 1996, Dr. Phillips has published numerous articles and a book on coronary artery stenting. He is active in training medical residents and cardiology fellows at Scripps Mercy and at UCSD where he is an Associate Clinical Professor. His current research interests include management of acute coronary artery syndromes and evaluation of muscle toxicity caused by cholesterol lowering therapies.

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Dr. Schim earned his medical degree and completed his neurology residency at UC San Diego. He practices general neurology in San Diego, with special interests in headache and pain management, stroke prevention and treatment, and neurologic rehabilitation. He has been principal investigator in many clinical trials for acute and preventive treatment of headache, stroke, and other neurological disorders. He has more than 13 years experience in the use of Botox for treatment of movement disorders, spasticity, headache, neck and back pain, and is a principal investigator in studies evaluating these emerging uses. Dr. Schim is an Assistant Clinical Professor of Neurology at UCSD, co-director of the San Diego Headache and Facial Pain Center, a member of the Medicare Carrier Advisory Board for California, President-elect of the Association of California Neurologists, Chairperson of Operation Stroke, San Diego, President of the American Heart Association, San Diego chapter, and an examiner for the Neurology Boards.

Name:	M. Scott Willson, MPH, MD
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Born and raised in California, Dr. Willson has served as the San Diego CAD Task force representative to the Southern California region-Kaiser from 2002-present. From 1985-present, he has been a staff physician, Family Medicine-Kaiser. 1980-84 Residency Doctor, Family Medicine, UCSD; 1976-79 Resident in Family Medicine, UCSD. From 1972-75, Dr. Jones attended Baylor College of Medicine in Houston,TX where he received his medical degree; from 1971-72 he earned his master's in public health from UC Berkeley; and from 1967-71, he earned his bachelor's degree of arts from UC Santa Barbara.

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Judith R. Yates is Vice-President and Chief Operations Officer of Healthcare Association of San Diego and Imperial Counties, a non-profit trade association

representing hospitals and health systems in the two-county area. Using her expertise in strategic planning, communications, team development, and program development, Yates' efforts support Healthcare Association's members as an advocate for affordable, medically necessary, quality health care services in the San Diego and Imperial County communities. Yates represents hospital members on numerous state-level issues through meetings of the California Healthcare Association including public affairs, disaster preparedness, EMS trauma, governance, nurse ratios, rural health policy, behavioral health, and accreditation. Locally, she is Chair of the Mental Health Board; co-chair of the Communications Collaboration Subcommittee of the SD County Health Advisory Committee on Terrorism; and member of the Public Health & Safety/Education, Training, and Communications Work Group of the Regional Network for Homeland Security Collaboration. Yates also participates locally in the Managed Care Advisory Group, Mental Health Commission, Operation Stroke Task Force, LPS Task Force, San Diego Regional Chamber of Commerce Health Committee, Downtown San Diego Partnership Social Action Collaborative, and on special issues including nursing/workforce, behavioral health, emergency medical services, and disaster planning. Yates is a member of the Healthcare Communicators of San Diego and is a founding member of the local chapter of the California Elected Women's Association for Education and Research (CEWAER). Yates holds a bachelor's degree of science in Nursing and a master's degree in Public Health. Prior to joining Healthcare Association in 1997, Yates was Assistant Director of the Orange County Health Planning Council; Assistant to The Medical Center CEO/Associate Director of Clinical Service Planning at the University of California, Irvine Medical Center; and Special Assistant to the CEO at the University of California, San Diego Medical Center.

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San Francisco Public Forum on Heart Disease and Stroke Prevention and Treatment

Summary of Key Findings

Panelists and community members highlighted the magnitude of problems related to heart disease and stroke in San Francisco and throughout the state of California and offered specific strategies to address these problems. This summary captures the key points presented by expert panelists and community members at the public forum held on March 18, 2004.

Specific Findings and Recommendations

QUESTION #1: WHAT ARE THE THREE MOST IMPORTANT CHANGES IN CALIFORNIA THAT NEED TO BE MADE IN ORDER TO REDUCE DEATH AND DISABILITY FROM HEART DISEASE AND STROKE?

The panelists offered many suggestions and most could be grouped under improving access to care and emphasizing prevention.

The panelists made the following specific recommendations to improve access to care:

- Establish access to quality healthcare (including preventive care) for all through healthcare reform legislation.
- Repair the fragmented healthcare delivery system so that high blood pressure and high lipids can be detected through better screening and controlled through better treatment.

To improve prevention of heart disease and stroke, panelists recommended:

- Promote policies and programs that increase access to fresh fruits and vegetables and opportunities for physical activity.
- Continue to reduce smoking, especially among teens; do not redirect cigarette taxes for other state purposes; the taxes are earmarked by the authorizing legislation for tobacco-control related activities.
- Make evidence-based preventive care available and affordable for every Californian.
- Educate all Californians in a culturally appropriate manner about the importance of stroke and heart disease prevention as a part of the school curriculum, local community events, and through community-based organizations.
- Build neighborhoods so that they promote health; every proposed development should be subject to a “health assessment review” in addition to environmental impact review.

QUESTION #2
WHAT DO PEOPLE IN CALIFORNIA NEED TO LEARN ABOUT HEART DISEASE AND STOKE? WHAT DO PHYSICIANS AND HEALTHCARE PROFESSIONALS NEED TO LEARN ABOUT HEART DISEASE AND STROKE?

There was general agreement among panelists that most people don't realize that they are more likely to die from heart disease or stroke than from any other cause. Furthermore, most people don't realize that they can change the odds of having a heart attack or stroke by modifying their behavior.

Californians
To support appropriate behavior change, the panelists recommended that the public be taught:

- That the risk of getting heart disease or having a stroke can be reduced by maintaining a normal weight, being physically active (at least 30 minutes per day), eating a low-fat diet that includes fruits and vegetables, not smoking, and keeping blood pressure and cholesterol levels at recommended levels.
- Men and women may experience the symptoms of heart attacks differently.
- The signs and symptoms of stroke.
- That after a heart attack or stroke, it is imperative to seek medical treatment immediately since outcomes are highly dependent on the how quickly treatment is sought and delivered.

Healthcare Professionals
This discussion grew from a focused dialogue on what providers need to learn to a wider discussion of clinical practices that will improve heart disease and stroke management. Specific recommendations included:

- Promote application of evidence-based guidelines.
- Promote population-based healthcare; that is, use of disease registries in conjunction with prompts and reminders to track patients who need regular care and follow-up.
- Promote use of standardized protocols; collect data to see if these protocols are being implemented by individual practitioners; provide feedback to providers so they can improve adherence to protocols.

In addition, there was considerable discussion of how stroke management should be improved. Panelists suggested:

- Encourage hospitals to establish stroke centers that meet JCAHO certification standards.
- Educate EMS staff to recognize stroke in the field so they can deliver patients to designated stroke centers.

- Educate emergency department staff about the importance of expedited TIA and stroke work-ups and triage.
- Educate primary care providers about the importance of aggressive management of risk stroke factors including high blood pressure, high cholesterol, diabetes, and atrial fibrillation.
- Educate hospital staff to appropriately manage the treatment for patients who suffer from strokes while in the hospital.

QUESTION #3:
WHAT NEEDS TO HAPPEN IN CALIFORNIA SCHOOLS, WORKPLACES, AND COMMUNITIES TO PREVENT HEART DISEASE AND STROKE?

Schools
Panelists offered suggestions on curriculum and environmental changes in schools that will start children toward a heart-healthy lifestyle at an early age.

Regarding, curriculum, panelists recommended:

- Provide quality physical education programs for both genders and in all grades, both during and after school.
- Integrate health content into social studies, chemistry, and other curricula.
- Educate children about heart disease and stroke risk factors.
- Educate children about the signs and symptoms of heart attack and stroke.
- Invite heart attack and stroke survivors into schools to tell their stories.

To make the school environment more heart-healthy, panelists recommended:

- Limit cafeteria offerings to heart-healthy foods.
- Encourage students to walk to school.

Workplaces
Discussion focused on the need to create workplace policies and facilities that favor healthy lifestyles. Panelists suggested policies that:

- Enforce no-smoking laws.
- Provide discounts or access to gyms.
- Make heart-healthy choices available in the cafeteria and vending machines.
- Provide adequate health coverage.

In addition, panelists recommended that employers make their facilities “activity-friendly” by:

- Providing lockers and showers and storage for bicycles.
- Providing outdoor areas that invite walking during breaks.

Communities
Panelists recommended that prevention strategies be "nested" in communities as follows:

- Community design should encourage healthy lifestyles:
- Heart-healthy foods should be readily available in markets and restaurants.
- Public places (community centers, senior centers, hospitals, DMV offices) should be used as sites for health education; materials should be in multiple languages.
- Automated External Defibrillators (AEDs) should be widely available in public places.
- Community-based CPR classes should be available.
- Communities should address the World Health Organization's ten social determinants of health (social gradient, stress, early life, social exclusion, work, unemployment, social support, addiction, food, transportation).

QUESTION #4:
WHAT NEEDS TO CHANGE IN THE HEALTHCARE SETTING TO IMPROVE: A) PREVENTION OF HEART DISEASE AND STOKE, AND B) QUALITY OF TREATMENT DELIVERED TO PATIENTS WITH HEART DISEASE OR STROKE?

Prevention
Panelists recommended changes in the healthcare delivery system, provider reimbursement, and medical education as follows:

- Better data systems should be installed to track and manage patients with risk factors such as high blood pressure, high cholesterol or diabetes; this allows the application of population-based prevention.
- Medical schools should teach the skills necessary for population-based prevention and treatment.
- High-risk patients should get prevention counseling.
- Prevention activities should be reimbursable.
- Physicians should use care extenders (nurse practitioners, pharmacists, peer counselors, social workers) to assist in prevention counseling.
- Use of evidence-based guidelines should be universal.

Quality of Treatment
Panelists emphasized the importance of quality improvement systems and professional education. They recommended:

- Establish continuous quality improvement systems; support use of this concept through periodic summits, conferences, publications.
- Use standardized protocols supported by evidence-based guidelines.
- Train healthcare professionals in the field (EMS) and in hospitals (ED staff) to recognize stroke early.

- Measure the performance of providers and hospitals against quality standards and publish reports for consumers to use in making healthcare choices.

QUESTION #5:
HOW CAN WE REDUCE HEALTH DISPARITIES IN HEART DISEASE AND STROKE?

For all people to receive the same high quality healthcare, barriers to access, communication and uniform delivery of treatment must be removed. Panelists suggested:

- Assure equivalent health insurance for all.
- Link reimbursement to evidence-based quality measures.
- Provide health education in the language used by the patient being served.
- Outreach to groups that may be receiving less than the highest quality care.

San Francisco Heart Disease and Stroke Prevention Public Forum: Tables with Panelists' and Public Comments

March 18, 2004, Kaiser Permanente Medical Center, 2425 Geary Boulevard, Mezzanine Rooms 1-3, San Francisco, CA 94115

Panelists:

Laura Brainin-Rodriquez, MPH, MS, RD
Coordinator *Feeling Good Project*
San Francisco Department of Public Health

Ralph Brindis, MD, MPH, FACC
Chief Regional Cardiology Advisor
Chair, National Cardiovascular Data Registry Task Force
Northern California Kaiser Permanente

David Ghilarducci, MD
Medical Director
Santa Clara County Emergency Medical Services Agency

Barbara Harrelson
Regional Vice President
Hospital Council of the South Bay

Khati Hendry, MD
Medical Director
Alameda Community Health Center Network

Dick Hodgson
Vice President, Policy and Planning
San Francisco Community Clinics Consortium

James Letchworth, RN
Cardiac Rehabilitation Coordinator
Kaiser Permanente, San Francisco

Antonio P. Linares, MD, FAAFP
Medical Director, Quality Improvement
Lumetra

Richard J. McCarthy, MD
Chief of Neurology
Chief of Quality Management
Kaiser Permanente

Karen Robertson Strain
Cardiopulmonary Resuscitation Training Director of Advocacy
American Heart Association, San Francisco

William Satariano, PhD
Professor of Epidemiology
UC Berkeley School of Public Health

Charles J. Toeniskoetter
Chairman of the Board, Real Estate Development and Investments
Co-Founder Stroke Awareness Foundation
Stroke Survivor

David C. Tong, MD
Associate Professor
Department of Neurology and Neurological Sciences
Stanford Stroke Center

Planning Committee:

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Staff:

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- Melba Hinojosa, RN, PHN, MA, Department of Health Services, California Heart Disease and Stroke Prevention Program
- John Kurata, PhD, MPH, Acting Chief, California Heart Disease and Stroke Prevention Program
- Nan Pheatt, MPH, Secondary Prevention and Professional Education Manager, California Heart Disease and Stroke Prevention Program, California Department of Health Services
- Heather Hutcheson, Program Coordinator, Center for Collaborative Planning
- Faye Kennedy, Program Associate, Center for Collaborative Planning
- Connie Chan Robison, Director, Center for Collaborative Planning

Number Attending
17 Audience Members
13 Panelists

Promotional Activities:
The Planning Committee for the forum forwarded the Save-the-Date flyer to local stakeholders, i.e., individuals or organizations who have a role or an interest in reducing the heart disease and stroke burden in the Bay Area. The Center for Collaborative Planning (CCP) sent press releases and Save-the-Date information to the area's state representatives, county supervisors, and the American Heart Association. CCP sent press releases to local media outlets, including print, radio, and TV through Congress.org. Outlets reached include:

- SF Weekly
- San Francisco Bay Guardian
- San Francisco Bay View
- San Francisco Chronicle
- SFCTC-TV (Channel 29)
- SFGTV (Channel 26)
- KCBS 740 AM
- KFRC 610 AM
- KGO 810 AM
- KQED 88.5 FM
- KSFO 560 AM

In addition, CCP forwarded the materials to individuals who were identified by planning committee members as stakeholders:

Peter Lee
President and Chief Executive Officer
Pacific Business Group on Health

Dr. Thomas Perry
Integrated Benefits Institute

Diane Stewart
Senior Project Manager
Pacific Business Group on Health

Dr. Tim Bridge
Chevron Texaco

Cathy Luginbill
Alta Bates Hospital

Sally Welborn
Wells Fargo

1. What are the three most important changes in California that need to be made in order to reduce death and disability from heart disease and stroke?

Panelist	Most Important Changes to be Made
Khati Hendry, MD Medical Director Alameda Community Health Center Network [written comments]	• Establish access to quality healthcare for all through healthcare reform legislation. • Support programs and policies that promote safe physical activity and healthful diets, and discourage substance use (including tobacco). • Support healthy communities through living wages, public education, and economic opportunity.
Laura Brainin-Rodriquez, MPH, MS, RD Coordinator *Feeling Good Project* San Francisco Department of Public Health [written comments]	• Eliminate trans fats from foods and assist businesses in California to do the same. • Promote public policies that increase access to fruits and vegetables in institutional settings. This includes schools, workplace cafeterias and other places where people buy food (e.g., Farmer's Markets in underserved neighborhoods, produce trucks, farm-to-consumer deliveries, fruit stands, etc.) • Promote public policies that increase access to places for recreation and physical activity, including urban planning policies that promote walking to school, work and within neighborhoods.
Ralph Brindis, MD, MPH, FACC Chief Regional Cardiology Advisor Chair, National Cardiovascular Data Registry Task Force Northern California Kaiser Permanente [written comments]	• After decreasing over past decades, tobacco use has stabilized. Further work in reducing teen smoking is needed; use the Prop 99 funds for their intended purpose: tobacco education and research; do not deflect funds for other state use. • Obesity is clearly a substantial challenge in California and the nation. Obesity leads to secondary increases in diabetes, hypertension, and diabetes management. This requires education, school nutrition oversight, pressure on the fast food industry, and general education. Exercise is important. Schools have cut back on formal physical education due to funding challenges. Statewide school physical education initiatives are needed. • Hypertension screening and blood pressure control is poor due to fragmentation of the healthcare delivery system, inadequate documentation, and lack of healthcare. Education as to new blood pressure targets, particularly in the elderly, and also diabetes management is needed (per JNC VII). • Elevated cholesterol is an issue. Both primary and secondary control is insufficient. Again, there is the

Panelist	Most Important Changes to be Made
Ralph Brindis, MD, MPH, FACC (cont'd)	secondary control is insufficient. Again, there is the problem of a dysfunctional healthcare delivery system, inadequate data collection, lack of understanding among healthcare professionals as to target cholesterol levels under the new ATP III lipid management guidelines, particularly patients with diabetes mellitus. • Diabetes mellitus management is needed.
Richard J. McCarthy, MD Chief of Neurology Chief of Quality Management Kaiser Permanente [written comments]	• Decrease the number of underinsured and uninsured Californians so that more patients have access to preventive care and treatment of stroke and heart disease. Currently, 6.7 million Californians (or 1 in 5 Californians) do not have health insurance. Over 80% of the uninsured are from working families. It is estimated that the number of uninsured Californians increases by 400,000 per year. More and more health insurance programs are creating high deductible or high co-pay insurance products in an effort to reduce skyrocketing healthcare insurance premium costs. As a result of this and the high cost of prescription drugs, obtaining appropriate preventive care may become financially difficult even for those Californians who do have health insurance. • California needs to create an affordable basic health insurance benefit package that insures that there are no financial barriers to obtaining preventive care. The average annual cost of treatment for ischemic stroke averages $50,000. Annual total direct costs of stroke are estimated to be about $30 billion in the United States. • It is estimated that about 50% of strokes could be prevented with control of high blood pressure, cessation of smoking and treatment of atrial fibrillation. Making evidence-based preventive care for stroke and heart disease accessible and affordable for every Californian is not only the right thing to do, but also the most cost-effective. • Educate all Californians in a culturally specific manner about the importance of stroke and heart disease prevention as a part of the school curriculum, local community events and through community organizations. About half of all strokes could be prevented by controlling the following risk factors: 1) High blood pressure increases the risk of stroke by

Panelist	Most Important Changes to be Made
Richard J. McCarthy, MD (cont'd)	10-12 fold. Treatment of high blood pressure reduces the risk of stroke by 25-47%. 2) Atrial fibrillation affects 6% of the population over 65 and increases the risk of stroke by 3-5 fold. Anticoagulation with Warfarin reduces the risk of stroke with atrial fibrillation by 68%. 3) Diabetes increases the risks of stroke two- to three-fold. Type 2 diabetes is directly related to obesity and inactivity. 4) Cigarette smoking increases the risk of stroke by 50%. 5) There is increasing evidence that treatment of high cholesterol with cholesterol-lowering medications ("statins") in patients that have atherosclerosis decreases the risk of stroke. • Educate all Californians in a meaningful way about the symptoms of stroke and heart disease and the need to seek urgent treatment. A majority of stroke patients wait hours or days before seeking treatment or ignore symptoms of TIAs, which are warning signs for an upcoming stroke. [verbal comments] • We need to stress prevention. Untreated risks, such as hypertension, blood clots, smoking, and diabetes can increase the risk of stroke and these risks are treatable. • Our real challenge is access to care. One in five Californians doesn't have access to care. Those with insurance have high co-pays and there are built-in disincentives to preventive care. • Education about preventive care needs to increase. It is not just the right thing to do; it is financially sound. • Seeking care—educating about the signs and symptoms of stroke is needed.
Dick Hodgson Vice President, Policy and Planning San Francisco Community Clinics Consortium	• The State of California and the US are not moving towards universal healthcare—this is amazing. If the state had a single payor plan it would save money, but the issue is: who should run it? Access to coverage gets people into care and reduces costs. The number one thing we need to do is move to a single payor plan/universal healthcare.

Panelist	Most Important Changes to be Made
William Satariano, PhD Professor of Epidemiology UC Berkeley School of Public Health	• Primary prevention is important for reducing heart disease/stroke. Physical activity/healthful diet/decreasing-stopping smoking are important. • The importance of healthful behaviors needs to be shared, but not just by telling people. We need to understand patterns of behavior; it isn't just a lack of will that keeps people from making changes. There is excellent research by the CDC regarding the effects of the environment on behavior change. • Obesity and adult diabetes are occurring earlier in life—this is all related to a more sedentary lifestyle. • Those who live in residential suburban communities that are less dense are less likely to walk, because destinations (e.g., the grocery store) are far away. It isn't just a lack of will or information. We need to think creatively about suburban design to integrate mixed use and health concepts. • A "health impact assessment" should be done, similar to an "environmental impact assessment." We need to identify the collateral health effects of programs/policies developed by the non-health sector.

Public Comments on Question #1:

Community Member	Most Important Changes to be Made
Sumedha Shende Library Manager, Kaiser Permanente San Francisco [written comments]	• We need public knowledge that heart attacks and strokes are preventable. • We need more stroke centers. • We need the inclusion of health topics in school.
Dan Ferguson, MD Catholic Healthcare West [written comments]	• We need health behavior change (diet/exercise/no tobacco). • We need health professionals to adopt demonstrated best practices in prevention and treatment of heart disease and stroke.
Roswitha Robinson Advocate for people with disabilities [written comments]	• We need better access to affordable healthcare and medication plans. • We need better education of the public, healthcare providers, teachers and care providers relative to risk factors and prevention of stroke and heart disease. • We need a partnership of the state with the AHA, health insurance carriers and the food industry.

2. What do people in California need to learn about heart disease and stroke? What do physicians and healthcare professionals need to learn about heart disease and stroke?

Panelist	Californians	Healthcare Professionals
Khati Hendry, MD Medical Director Alameda Community Health Center Network [written comments]	• Heart disease is the number one cause of death and is largely preventable. • People should know the risk factors, and what their risk is. • Everyone needs regular healthcare check-ups, because the problems start without symptoms.	• We need to know how to identify high-risk patients, how to counsel them, how to work with community resources, and how to treat the patients. • We need to learn how to do population-based healthcare, with resources such as registries, with prompts and reminders to track patients needing regular care and follow-up. • We need to have easy access to common, unbiased, established guidelines and relevant updates appropriate to our specialties. We do NOT need multiple versions of materials from different managed care plans, and should NOT be getting our information from sources subsidized by pharmaceutical companies.
Laura Brainin-Rodriquez, MPH, MS, RD Coordinator *Feeling Good Project* San Francisco Department of Public Health [written comments]	• Educating the public about the importance of screening for the markers of heart disease and stroke risk such as homocysteine, C-reactive protein and lipid profiles. • That small changes in weight (a 5-10% loss) and activity (30 minutes per	• Educate providers about the negative impact of trans fast and high-sugar diets on risk of heart disease and stroke.

Panelist	Californians	Healthcare Professionals
Laura Brainin-Rodriquez, MPH, MS, RD (cont'd)	day) for an unfit sedentary person results in tremendous reduction in health risk (50%) for heart disease and improves management. • Educate the public about the negative impact of trans fats and high-sugar diets on risk of heart disease and stroke. • Fund public campaigns to promote alternatives to eating trans fats and refined sugars, taking advantage of the many diverse cultures in California and the unique culinary wisdoms they possess.	
Ralph Brindis, MD, MPH, FACC Chief Regional Cardiology Advisor Chair, National Cardiovascular Data Registry Task Force Northern California Kaiser Permanente [written comments]	• Increased awareness of women and heart disease. Women need to know heart disease is their number one killer, it presents later in life than it does in men, and often presents with symptoms that are atypical compared to men. Women have been educated regarding	• Continued increased awareness and education related to women and heart disease (atypical clinical presentations, etc.). • Updates related to new clinical guidelines for cholesterol management and hypertension management, particularly in diabetic population (ATP III cholesterol and JNC VII hypertension guidelines). • Teaching to increase effectiveness in treating

Panelist	Californians	Healthcare Professionals
Ralph Brindis, MD (cont'd)	breast cancer risk but aren't aware their risk is higher for heart disease/stroke. • Understanding symptoms of myocardial ischemia/infarction to decrease symptom-to-door time and increase the ability to institute timely treatment in acute myocardial infarction. Symptom-to-door time has not changed in last decade. Maximal positive outcomes in "golden hour" after initial symptoms. But half of all patients do not use EMS; instead they will wait and drive themselves to the hospital or the doctor's office. • Continued education related to risk factor modification. • State of California should use tobacco tax money for heart disease and stroke education. Have had a decrease in smoking; now have risk with teenagers.	obesity, type 2 diabetes, hypertension, and smoking cessation—role of disease management programs, focused interventions programs, extended use of health professionals in risk factor-oriented programs. • The power of data collection, standardized protocols, and outcomes data for direct feedback to bring about positive change in clinical results. *[Additional verbal comment]* • In the State of California we have a proposition for tobacco education and research. We should use the funds for stroke and heart education also. We have had a decrease in tobacco use, now the risk is with teenagers.

Panelist	Californians	Healthcare Professionals
Barbara Harrelson Regional Vice President Hospital Council of the South Bay		• More hospitals should develop stroke programs and become stroke centers. • Pre-hospital side: ambulance staff should be trained to deal with stroke patients and prevention.
David Ghilarducci, MD Medical Director Santa Clara County Emergency Medical Services Agency		• Prevention is most important. Money is better spent on prevention than on care after a person is in the emergency room. • A stroke alert system should be set up to notify a hospital that a possible stroke has happened; the patient should be transported to a hospital set up to deal with strokes. • One challenge—there isn't a lot of data on the EMS side for the advantages of going to a stroke center and it is difficult to identify a stroke in the field. We need to be careful about transporting patients to a stroke center without identifying that they are indeed having a stroke. • In regard to recognizing signs of stroke, we have a long way to go. We are much better at identifying heart attacks.
David C. Tong, MD Associate Professor Department of Neurology and Neurological Sciences		• There is a need for triage and a lot we can do with education. There is not enough education for EMS or emergency room staff. • With regard to comments made disputing the efficacy of stroke centers, there is evidence that stroke center systems work and that triage time for treatment dramatically drops. The

Panelist	Californians	Healthcare Professionals
David C. Tong, MD (cont'd)		dramatically drops. The problem is training; not that we can't do this.
Charles J. Toeniskoetter Chairman of the Board, Real Estate Development and Investments Co-Founder Stroke Awareness Foundation Stroke Survivor	• I knew nothing about signs and symptoms of stroke despite having a high level of education. • Education should occur with the public—it is crucial that people know what to do and where to go if they have a stroke.	• Establish stroke centers certified by JCAHO. This is critical. • Emergency services personnel should be trained to identify strokes and to get patients to a stroke center. • Results of a study in East Texas by the University of Michigan should be used to prove success of doing the things I suggest, including administering the clot-buster, tPA, as appropriate.
Richard J. McCarthy, MD Chief of Neurology Chief of Quality Management Kaiser Permanente [written comments]	• The causes of stroke and the importance of prevention. • The symptoms of stroke and heart disease and the need to seek urgent treatment for these symptoms. • Finally, healthcare consumers should be aware of the data available from external quality reviews available from independent organizations like the CCHRI, NCQA, CalPERS, the California State Office of the Patient Advocate, and consumer organizations like Consumer Reports so that they can make wise decisions	• The importance of expedited work-ups for transient ischemic attack (TIA) and stroke. • The importance of: aggressive management of hypertension, diabetes and high cholesterol; screening for atrial fibrillation and treatment of atrial fibrillation with Warfarin anticoagulation. • The need to establish pre-printed orders and multidisciplinary care pathways for the treatment of stroke and the use of "clot buster" drugs. • Lastly, physicians and healthcare professionals need to know that they are the most effective venue for education of patients to stop smoking and increase physical activity and one of the most effective venues for education about the risk of stroke and heart disease and

Panelist	Californians	Healthcare Professionals
Richard J. McCarthy, MD (cont'd)	in deciding which health insurance to purchase.	stroke and heart disease and the importance of prevention.

Public Comments on Question #2:

Community Member	Californians	Healthcare Professionals
Consuelo Yokum Cardiac CNS O'Connor Hospital		• We need to be prepared for the in-hospital stroke event; we need to think about more than just the people coming in with a stroke. In regard to physical therapy: if there is not immediate improvement in the patient, then funding is not forthcoming.
David Tong, panelist, responded:		• The in-hospital stroke is an education of the staff issue. It is relatively rare and yet when it happens patients are right there in the hospital so we should be able to treat them effectively. • We need physical medicine combined with stroke rehab centers; this is an under appreciated long-term treatment. There are models in Europe for prevention of complications.
Sumedha Shende Library Manager, Kaiser Permanente [written comments]	• Need to stop smoking, eat more vegetables, and learn that stroke is preventable.	
Dan Ferguson, MD Catholic Healthcare West [written comments]		• Need to understand demonstrated best practice and then apply it to preventive and therapeutic interventions in a standardized and disciplined way.

Community Member	Californians	Healthcare Professionals
Roswitha Robinson Advocate for the people with disabilities [written comments]	• Heart disease and stroke are preventable in a large number of people. • Regular physician check-ups are essential to evaluate risk factors and health status. This includes individuals with developmental disabilities. • Stroke and heart disease are connected to aging, diabetes, genetics, high cholesterol, hypertriglyceridemia, high blood pressure, obesity, physical inactivity, tobacco and alcohol. • Obesity in connection with physical inactivity frequently leads to diabetes, which significantly increases the risks for heart disease and stroke. • Proper nutrition and exercise are essential for prevention.	• Screening their patients, including those with developmental disabilities, for risk factors in accordance with the AHA guidelines is essential. Time needs to be taken to explain the importance of the treatment plan. • Persons with developmental disabilities have the same risk factors as everyone else. • The approach to care for a patient from a different country should take cultural differences into consideration. • There are physicians specializing in preventive cardiology. • There are excellent educational materials available through the AHA and the ASA.

3a. What needs to happen in California SCHOOLS to prevent heart disease and stroke?

Panelist	Schools
Khati Hendry, MD Medical Director Alameda Community Health Center Network	• Good physical education programs for all grades and genders both during school and afterwards. • Space for children to move and play, and safe recess time.

Panelist	Schools
Khati Hendry, MD (cont'd) [written comments]	time. • Schools should work with parents and the community to promote safe ways for children to walk to school, such as "walking buses," crossing guards, and safe sidewalks and streets in neighborhoods. • Sodas and unhealthful foods, such as brand name fast food, should be banned from the premises, and healthful food choices made available.
Laura Brainin-Rodriquez, MPH, MS, RD, Coordinator *Feeling Good Project,* San Francisco Department of Public Health [written comments]	• Schools should model the way we want people to eat for a lifetime. We should figure out ways kids can walk to school.
Ralph Brindis, MD, MPH, FACC Chief Regional Cardiology Advisor Chair, National Cardiovascular Data Registry Task Force Northern California Kaiser Permanente [written comments]	• Nutritional expertise and oversight in the food services for school systems. • Formal education in the school system at early ages with continued reinforcement on risk factor modification in heart disease.
Karen Robertson Strain Cardiopulmonary Resuscitation Training Director of Advocacy American Heart Association, San Francisco	• School education and structured physical education (so many minutes per day) are needed. It is very important to have credentialed physical education teachers. In regard to food—nutritional programs should be provided at all schools. Key education in schools should occur at an early age.
William Satariano, PhD Professor of Epidemiology UC Berkeley School of Public Health	• In grades K-12—Physical education integrated through the day, and healthful foods made available. • Integrate more health content into social studies, chemistry, biology curriculum, etc., and health content should be provided in high school. For example, the Berkeley School of Public Health is working with Oakland Tech High School and two middle schools to integrate more health content into the curriculum.

Panelist	Schools
Dick Hodgson Vice President, Policy and Planning San Francisco Community Clinics Consortium	• Health education has stood outside of the regular curriculum. It should be an important education subject. • We need to convey to kids the importance of health education.
Richard J. McCarthy, MD Chief of Neurology Chief of Quality Management Kaiser Permanente [written comments]	• Renew a focus on physical education and sports. • Educate students about the importance of a heart-healthy diet to decrease cholesterol and decrease obesity. • Make heart-healthy school lunches. • Promulgate curriculum in schools that includes education about risk factors for atherosclerosis and symptoms of stroke and heart attack.

Public Comments on Question #3a:

Community Member	Schools
Sumedha Shende Library Manager, Kaiser Permanente, San Francisco [written comments]	• Present students with data. • More speeches by stroke patients in school.
Roswitha Robinson Advocate for people with disabilities	• A partnership between the food industry and schools needs to be developed to provide healthier and tastier foods. • It is imperative to limit the kinds of food and beverages known to be harmful to children. • Physical education needs to have more emphasis. • Questionnaires for cardiac risk factors need to be distributed in high schools.

3b. What needs to happen in California WORKPLACES to prevent heart disease and stroke?

Panelist	Workplaces
Khati Hendry, MD Medical Director Alameda Community Health Center Network [written comments]	• Need to support physical activity by: - Provide showers and lockers. - Have landscaped premises conducive to activity during breaks and lunch hours. - Have places for people to store bicycles. - Have policies that encourage participation in physical activity such as flexible hours, discounts/ access to

Khati Hendry, MD (cont'd)	gyms, or sponsoring sports activities. - Have healthy foods in vending machines and cafeterias. - Have opportunities for people to move about periodically. - Rules against smoking should be enforced. - Workplace leaders should champion healthful behaviors, including reasonable work hours and vacation policies. • Larger sites might provide health promotion activities such as blood pressure, sugar and cholesterol checks, BMI measurement, and materials people can use to calculate their risks. • Of course, all workplaces should provide adequate health coverage, in the absence of other healthcare reform. • Workplaces should provide a living wage.
William Satariano, PhD Professor of Epidemiology UC Berkeley School of Public Health	• We need to consider many of the same issues as in the schools: physical activity, nutritious foods, etc. • Include the need for shower facilities for those who ride their bikes to work. • After a health crisis, a person who is returning to work should be given more flexibility in terms of schedule and work load, etc.

Public Comment on Question #3b:

Community Member	Workplaces
Roswitha Robinson Advocate for people with disabilities [written comments]	• Workplaces need to offer affordable health-promoting educational opportunities.

3c. What needs to happen in California COMMUNITIES to prevent heart disease and stroke?

Panelist	Communities
Khati Hendry, MD Medical Director Alameda Community Health Center Network [written comments]	• Communities should address the social determinants of health. • The WHO has identified 10 major social determinants, including the social gradient, stress, early life, social exclusion, work, unemployment, social support, addiction, food, and transportation.

Panelist	Communities
Khati Hendry, MD (cont'd)	• At a minimum communities need to have: ▪ Safe places to play and walk. ▪ Pedestrian- and bicycle-friendly streets. ▪ Opportunities for people to easily obtain healthful food. ▪ Effective health promotion systems (through public health or other institutions) and ▪ Access to healthcare. ▪ Community-wide "walking clubs" sponsored by various entities have been effective in a number of locales.
Laura Brainin-Rodriquez, MPH, MS, RD Coordinator *Feeling Good Project* San Francisco Department of Public Health [written comments]	• The promotion of public policies that increase access to healthful foods (technical assistance to improve vending machine and purchase options). • The promotion of public policies that increase access to recreational and physical activity opportunities. • Educational campaigns and support for environmental changes to increase access to healthful diets free of trans fats, low in sugar and high in fruits and vegetables and heart healthy fats (olive oil, omega-3 fats). • We need to alter the environment and promote behavior change—make healthful choices easier. • Also we've known that folic acid reduces birth defects. Now we are learning it can reduce the risk of cardiovascular diseases. • We need to keep the messages simple. If people lose 5-10% body weight and exercise 30 minutes a day they can reduce their risk of cardiovascular disease by 50%. • We need to address how to make it easier for people to buy fruits and vegetables and to exercise. • We need to minimize the burden on hospitals of data collection – reduce double and triple entry, to leverage resources. • We need to improve the coordination of cardiac stroke services and make defibrillators more widely available and more widely used.
Ralph Brindis, MD, MPH, FACC Chief Regional Cardiology Advisor Chair, National Cardiovascular Data Registry Task Force [written comments]	• Formal education should occur in community centers, hospitals, and senior centers related to heart disease management, risk factor diagnosis and control, and symptom recognition to decrease symptom-to-door time. • There should be increased penetration of community-based CPR classes and defibrillator placement in public locations.

Panelist	Communities
Dick Hodgson Vice President, Policy and Planning San Francisco Community Clinics Consortium	• Healthcare providers should be addressing CVD risk factors: obesity, hypertension, and cholesterol. • Need to have healthcare professionals understand the importance of data collection on feedback. MDs have not yet bought into data collection. • EMS services must be better coordinated. However there are multiple financial, governmental, and political barriers to coordination.
James Letchworth, RN Cardiac Rehabilitation Coordinator Kaiser Permanente, San Francisco	• This is what I tell my patients: Mom was right; we need to eat our vegetables, play, don't smoke and take our cholesterol medication (I add this…) We all know this information; it is not a big secret. There are two big things we need to do: ・ Educate the general population regarding the signs and symptoms of a cardiovascular event. ・ Educate people to understand that they can prevent an event. • In working with my patients I tend to keep things simple. I advise them to: ・ Eat 5 fruits and vegetables a day. ・ I tell them all the little things do add up (that is, eating badly over time). ・ Get outside and play. ・ Do stress reduction.
Antonio P. Linares, MD, FAAFP Medical Director, Quality Improvement Lumetra	• We have good frameworks for quality improvement. The Institute for Medicine has a framework for the care that is most effective and can achieve best outcomes and also for care that is sub-optimal; we need to close the gap between the two. • We need to have standard orders. Translation: evidence-based standards need to be put into practice. • We need standard language for quality care measures. • We need registries and other tracking mechanisms. • We need quality improvement and need to be able to measure improvement. • The consumer needs to understand the dimensions of care and the consequences of not getting quality care. • Community-based collaboration is a tremendous model. • Our leadership and culture needs to embrace the concept of quality of care. • We need to utilize electronic data collection—there's a national plan; and California can be a leader in quality measurement.

Panelist	Communities
Barbara Harrelson Regional Vice President Hospital Council of the South Bay	• Financial reimbursements need to be addressed and there needs to be a "champion" who can get buy-in from everyone • We should utilize the AHA's "Get with the Guidelines."

Public Comments on Question #3c:

Community Member	Communities
Roswitha Robinson Advocate for people with disabilities [written comments]	• Educational materials in multiple languages need to be readily available in gyms, cultural centers, at the Department of Motor Vehicles (DMV), recreation centers as well as board and care homes.
Catherine Waters Associate Professor University of California San Francisco	• We should be creating safe social and physical environments promoting health. • We need to work with corner stores and restaurants, getting the community involved to prevent heart disease at the grassroots level. • There are lots of places to access care—but they are underutilized because they are not easy to reach, people don't feel respected, services are available to only some people—these are quality issues. • We need to educate and promote increased patient/provider communication, so people feel respected, and listened to. Get the community involved.

4. What needs to change in the healthcare setting to improve a) prevention of heart disease and stroke, and b) quality of treatment delivered to patients with heart disease or stroke?

Panelist	Prevention	Quality of Treatment
Khati Hendry, MD Medical Director Alameda Community Health Center Network [written comments]	• The healthcare setting needs better data systems, tools and training to identify and track patients at highest risk, such as those with hypertension, diabetes, obesity, hyperlipidemia, and tobacco use. • This requires support	• Continuous Quality Improvement (CQI) programs should be in place, focusing on the quality of care for patients with heart disease and/or stroke. These programs may be initiated in hospitals, outpatient clinics, group practices, academic settings, health plans, foundations or professional

Panelist	Prevention	Quality of Treatment
Khati Hendry, MD (cont'd)	staff and information systems to ensure that population-based care is effective. • Healthcare educational institutions need to incorporate this approach in their curricula. • Patients at high-risk should receive health education, nutrition counseling, medical and social case management if indicated, and be supported so they can develop their own self-management skills. • Financial reimbursement systems should be aligned so these support services are provided to all patients who need them. • Physicians who see patients at a frantic pace are bound to miss things and they may be poorly trained to counsel patients with chronic illnesses. Other health staff such as nutritionists, nurses, health educators, social workers, and mental health counselors may be necessary to ensure full care; this is often not available because there is no way to get paid for it.	groups. • Coordination and communication among those involved in quality improvement should be supported through periodic conferences, publications, summits, and electronic connections to accelerate learning throughout the state. • Healthcare collaboratives (e.g., in diabetes and asthma) are examples of models worth replicating.

Panelist	Prevention	Quality of Treatment
Laura Brainin-Rodriquez, MPH, MS, RD Coordinator *Feeling Good Project* San Francisco Department of Public Health [written comments]	• Screening should occur for the markers of heart disease and stroke risk such as homocysteine, C-reactive protein, and lipid profiles. • We should educate the public about the importance of screening for heart disease. • We should promote the understanding that some small changes in weight (5-10%) and activity (30 minutes per day) for an unfit sedentary person result in tremendous reduction in health risk for heart disease and diabetes (50%) and improve management in already diagnosed people.	• Sufficient resources should be provided to promote the lifestyle changes associated with reduced risk and improved recovery from heart disease. These promotion activities include: support groups, a prescription for physical activity, nutrition education and counseling, insurer-subsidized health club memberships for people following a risk reduction program, etc.
Ralph Brindis, MD, MPH, FACC Chief Regional Cardiology Advisor Chair, National Cardiovascular Data Registry Task Force Northern California Kaiser Permanente [written comments]		• We should assure the utilization and application of evidence-based medicine and guidelines implementation through: • Data collection using standardized definitions. • Outcomes assessment (for example, use of national registries such as American Cancer Society registries, the ACC-NCDR, etc.) • The benchmarking of outcomes, ideally risk-adjusted to assess bridging the science into practice and converting the effectiveness demonstrated

Panelist	Prevention	Quality of Treatment
Ralph Brindis, MD, MPH, FACC (cont'd)		in clinical studies to efficacy at the patient level across the practice continuum in the real world. • The use of pre-printed order sheets. Also, discharge plans, local cardiac champions, and treatment algorithms. • The consideration of pay-for-quality initiatives to help motivate change: for example, the Virginia model-partnership of Virginia American College of Cardiology, Virginia Quality Improvement Organization, Anthem (payer), GAP implementation tools, and infrastructure collection engine for data. Also, AHA's "Get With the Guidelines", "NRMI CRUSADE." • Minimize the hospital and practitioner data collection burden by working to avoid duplication of reporting to various regulatory agencies. (Databases used to collect information for CQI should be able to interface, so data need only be collected once; right now, hospitals have to choose between CQI programs or pay for data entry into multiple databases.)

Panelist	Prevention	Quality of Treatment
David C. Tong, MD Associate Professor Department of Neurology and Neurological Sciences Stanford Stroke Center		• We will have the most impact by educating healthcare providers. We have the technology but not everyone has the information. • Training emergency room personnel to identify stroke symptoms—we need to disseminate information. People are afraid of lawsuits; this is only a problem if they are left without back-up.
Richard J. McCarthy, MD Chief of Neurology Chief of Quality Management Kaiser Permanente [written comments]	• Establish scientific evidence-based goals for prevention and tie financial incentives to these goals.	• Eliminate practice variation and non-integrated healthcare practices that increase the chance of error, waste valuable healthcare resources, and promote non-scientific, non-evidenced-based care of stroke and heart disease. • Encourage multidisciplinary stroke and heart disease guidelines, pathways and pre-printed orders for emergency rooms and hospital units that are effectively implemented. • Measure and publicly report outcomes for prevention and treatment of stroke and heart disease. • By following these practices on a large scale over the last 10 years, one of the largest healthcare organizations, Kaiser Permanente, has had tremendous success; now for the 3.2 million Kaiser members in Northern

Panelist	Prevention	Quality of Treatment
Richard J. McCarthy, MD (cont'd)		California, heart disease is no longer the leading cause of death although it remains so in the general population. The mortality rate after a heart attack at Kaiser Permanente hospitals is up to 50% lower than at hospitals in the same communities across the state due to an integrated, evidence-based population approach to healthcare delivery.

Public Comments on Question #4:

Community Member	Prevention	Quality of Treatment
Sumedha Shende Library Manager Kaiser Permanente, San Francisco [written comments]		• Must have at least one champion in every hospital.
Roswitha Robinson Advocate for people with disabilities	• The following comments are submitted with the developmental disability (DD) community in mind: ・There are approximately 180,000 persons with DD in California. The disability is life-long. Every year, approx. 11,000 new individuals are diagnosed, 40% of them have autism. Obesity is a common finding in persons with DD. The life	• The following comments are submitted with the developmental disability (DD) community in mind. ・The following are needed: ・University-based and community-based teaching programs for healthcare providers. ・Specific training of caregivers. ・Improvement in standard of care.

Community Member	Prevention	Quality of Treatment
Roswitha Robinson (cont'd)	expectancy is 69 years. There is fragmentation in healthcare services. A large percentage of this population is under-served. · Better access to quality healthcare. · Improvement in continuity of care. · Stream-lining of healthcare. · Sensitivities towards people with developmental disabilities and those from minority communities with different cultures and languages. · Educational opportunities for care providers.	

5. How can we reduce health disparities in heart disease and stroke?

Panelist	Opportunities to Reduce Disparities
Khati Hendry, MD Medical Director Alameda Community Health Center Network [written comments]	• It is essential to address the social determinants of health mentioned in question three (3). • Neighborhoods need low-cost and free, safe exercise options such as walkable streets. • Access to quality healthcare is needed by all. • Services in communities and healthcare systems need to be in the language of the people they serve, physically accessible, and psychologically welcoming. • Special programs developed for outreach to particular communities at high-risk, based on public health data, should be supported. • Community health centers have historically been effective in reducing disparities by delivering high quality, multi-service care to populations at increased risk, and their chronic care and prevention programs in particular should be supported.

Panelist	Opportunities to Reduce Disparities
Khati Hendry, MD (cont'd)	• As part of their training, health professionals need to learn languages and other skills that will enable them to communicate effectively with the population of California. • The Department of Health should track epidemiological data to identify disparities, share the information with local health entities, and use the information to influence resource allocation to needy areas. [Additional verbal comments] • Many disadvantaged people can't take vacations for stress reduction. They have no education, and there is no physical activity for their children in their schools. There is an inequality in our society—we need an Unequal Health Impact Analysis, if we want to change health and how we live life. There are many people who have no money to go to the gym, who are working two jobs, and have no access to fruits and vegetables. • We need counseling, nutritionists, and specialists readily available with interpreter services as needed. This is critical --How can you educate if you can't communicate? • If people aren't seen at the community clinics they end up at the emergency room, which is far more costly. We almost lost our county hospital in Alameda. Heart disease is the number one cause of death so health services are crucial and having a champion works.
Ralph Brindis, MD, MPH, FACC Chief Regional Cardiology Advisor Chair, National Cardiovascular Data Registry Task Force Northern California Kaiser Permanente [written comments]	• Assure and implement uniform health insurance for all. Cover the uninsured. • Increase education awareness to women, and reach out to our diverse ethnic populations utilizing "same language" educational products teaching risk reductions and therapies in heart disease. Outreach to churches and local community centers for education and heart disease screening. • Collect data.
David Ghilarducci, MD Medical Director Santa Clara County Emergency Medical Services Agency	• There is controversial evidence for the use of tPA—some believe that it will help within a three-hour window. Any hospital can provide it, but more education at the emergency room level is needed.

Panelist	Opportunities to Reduce Disparities
David Ghilarducci, MD (cont'd)	• We need champions for stroke and cardiac care. Written protocols are needed and checklists. The delay doesn't occur with EMS; it happens when the signs and symptoms of stroke are not recognized by the patient and/or the family. Every hospital should be able to address stroke aggressively.
Charles J. Toeniskoetter Chairman of the Board, Real Estate Development and Investments Co-Founder Stroke Awareness Foundation Stroke Survivor	• Preventive care is wonderful and we need to make the changes in the schools. Challenge: I did all the correct things and I still had a stroke. 85% of strokes occur with folks who are 65 or older—habits will continue. • Hospitals and doctors should talk to groups, especially older folks as to what to do—education (signs and symptoms and then what to do). • There should be certified centers to be ready to deal with a person coming in with a stroke or heart attack. • We need to minimize the devastating effects of strokes. We need targeted interventions to decrease the disparities and identify early symptoms. • We need a care model for California—each community should identify its resources, IT systems, educate patients, have active care teams—develop a model to address health disparities in California.
Richard J. McCarthy, MD Chief of Neurology Chief of Quality Management Kaiser Permanente [written comments]	• Increase public reporting of prevention and treatment outcomes. • Link reimbursement to scientifically valid evidence-based quality measures. • Provide a mechanism for the uninsured to get reasonably priced health insurance. • Eliminate under-insurance that discourages preventive care by ensuring the availability of reasonably priced preventive care in a base health insurance benefit for all insurance products sold in the state. • Target efforts to populations most at-risk for heart disease and stroke.

Public Comments on Question #5:

Community Member	Opportunities to Reduce Disparities
Sumedha Shende Library Manager Kaiser Permanente, SF	• Exercising. • Weight reduction. • Data collection.

Community Member	Opportunities to Reduce Disparities
Tien T. Bo, PharmD Bayer HealthCare [written comments]	• New England Journal of Medicine article a few years ago citing the incidence of stroke in heart surgery patients to be about 6-18%. How does the panel feel about strategizing to provide better care for this group?
Roswitha Robinson Advocate for people with disabilities [written comments]	• Increase sources of healthcare services for all minorities and disadvantaged persons, including those with developmental disabilities. • Ensure proper healthcare access for minorities and the disadvantaged. • Ensure continuity of care. • Make access to healthcare services less complicated. • Ask health insurance carriers to financially support therapeutic lifestyle changes. • Integrate healthcare services for individuals with developmental disabilities into diverse community programs. • Establish university-based training programs in accordance with the American Academy for Developmental Medicine and Dentistry. • Promote healthful lifestyles.

Panelists' Open Microphone Comments

Panelist	Comments
Laura Brainin-Rodriquez, MPH, MS, RD Coordinator *Feeling Good Project* San Francisco Department of Public Health	• People end up in the emergency room because healthcare services are not offered during the hours when people need them. • Regarding trans fats—there is no safe level of trans fats, and there will not be labeling for several years. We need to partner with industry; given the increase with heart disease and diabetes there is no reason to tolerate trans fats in food. • Regarding refined sugar—sodas have become the primary source of calories, and this is having dire consequences.
Khati Hendry, MD Medical Director Alameda Community Health Center Network	• We are concerned about healthcare costs, and yet we allow pharmaceutical companies to subsidize conferences, etc. We should be negotiating the costs of medications. • We've made progress with tobacco cessation; we should use the tax money to remediate the effects of advertising. We allow huge amounts of resources to be used to promote things that have horrible health

Panelist	Comments
Khati Hendry, MD (cont'd)	effects (compare the money used for public health campaigns to money used by Pepsi for advertising). If we don't allow advertising for cigarettes anymore, we may want to consider not allowing other things that are detrimental to health to be advertised. • In regard to diabetes—we need to coordinate our efforts. Diet, exercise—let's do something coordinated for a change, we need to work together better.
Richard J. McCarthy, MD Chief of Neurology Chief of Quality Management Kaiser Permanente	• Almost every hospital in the state with a stroke champion can improve stroke care. It is not unattainable. We need to provide tPA. But stroke centers are not just about providing tPA. We need to make the effort, find champions and create multidisciplinary pathways to address stroke. • We need to be reporting health outcomes publicly, and healthy competition between hospitals should be encouraged. And, we need to improve the link between reimbursements and extra effort.
William Satariano, PhD Professor of Epidemiology UC Berkeley School of Public Health	• Why do only some people develop the disease? Why are some people diagnosed earlier? Why do some people get treatment? Why do some people do better than others? When research is done, patterns emerge; to decrease disparities, we need to develop programs that address these patterns. • We have a very diverse state; people at one end of the state are not getting the same treatment as people in other areas of state. We need to be aware of other conditions that relate to outcomes, e.g., aging. • We need to read other action plans and look for points of convergence; it will be more cost-effective, and we will achieve ends in a more efficient way. We need a coordinated plan of surveillance. There is now an environmental health surveillance system in California; perhaps it can be a model or be utilized. We need to move away from categorical diseases.
Antonio P. Linares, MD, FAAFP Medical Director Antonio P. Linares, MD, FAAFP Quality Improvement Lumetra	• We should pay for quality; pay for performance. The Medicaid Quality Control Pilot Initiative could be used. • We are using our emergency rooms as primary care centers and then there is no follow-up. It is the worst of the worst for the uninsured/underinsured. • We shouldn't create new resources; we should identify existing community-based resources to fund. We need early intervention for populations at risk.

Panelist	Comments
Ralph Brindis, MD, MPH, FACC Chief Regional Cardiology Advisor Chair, National Cardiovascular Data Registry Task Force Northern California Kaiser Permanente	• There is the issue of appropriateness. We need to avoid another Redding fiasco in which people allegedly received unnecessary cardiac surgeries. We need to get care to the right people at the right time regarding the right problem—that's what is meant by appropriateness. • Questions like how many echocardiograms should be ordered, primary angioplasty/PCI; these are very difficult questions. We have an uncoupling of onsite surgical standby; some hospitals are doing PCI without surgical standby. We need to evaluate the effect this is having on quality.
David Ghilarducci, MD Medical Director Santa Clara County Emergency Medical Services Agency	• We should identify criteria that would make up a cardiac care center. The data are there.
Richard J. McCarthy, MD Chief of Neurology Chief of Quality Management Kaiser Permanente	• Need to educate stroke patients and families to decrease risk of secondary strokes (not just give them a packet of information). Need a multidisciplinary approach and evaluate if people understand what we are trying to tell them.
James Letchworth, RN Cardiac Rehabilitation Coordinator Kaiser Permanente, San Francisco	• We have food industry opposition; our sense of portions has been affected. We could use the sushi model. • We should require that the daily-recommended calories be displayed at McDonald's. • We need to increase blood pressure screening. • There are industries we can work with. Why do we subsidize meat and dairy? Why not walnuts and olives?
David C. Tong, MD Associate Professor Department of Neurology and Neurological Sciences Stanford Stroke Center	• We are concerned about unfunded mandates. Who's collecting the data? And, who will fund data collection? Who will do mandated items? And, who will fund? • We need to keep things as simple as possible. Physician guidelines—keep information simple.
Antonio P. Linares, MD FAAFP Medical Director, Quality Improvement Lumetra	• Some tasks can change and make a significant impact. The Governor was a spokesperson for an exercise program in '94-'95…we need to bring it back, revitalized.

Panelist	Comments
William Satariano, PhD Professor of Epidemiology UC Berkeley School of Public Health	• We need to think about how the recommendations from the panel can be done, especially in concert with other charges the state faces. • Regarding environmental design—many health outcomes are impacted by environmental design and designers may not have health on their minds. We need to figure out ways to do this without going broke.
Laura Brainin-Rodriquez, MPH, MS, RD Coordinator *Feeling Good Project* San Francisco Department of Public Health	• Keep the message simple. • Promote collaboration between chronic disease programs. • Affect policy. Use taxes. • Advertising for foods we know are unhealthful are now tax-exempt—they should be taxed. • Address environmental issues.

Panelist's Biographies

Name:	Laura Branin-Rodriguez, MPH, MS, RD
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Laura Brainin-Rodriguez, MPH, MS, RD, is with Nutrition Services of San Francisco Department of Public Health. She provides staff and provider training and consultation and develops and implements community nutrition education programs for the California Nutrition Network. Ms. Brainin-Rodriguez provides technical assistance and resources to SF DPH staff, community based organizations and agencies on how to promote healthy nutrition and physical activity in their programs. Laura Brainin-Rodriguez currently serves in the SFUSD Nutrition and Physical Activity Committee that is drafting the implementation guidelines for the SF School Board Resolution seeking to improve the nutritional quality of foods served in SF public schools. She has a master's degree in nutrition and a master's degree in Public Health Nutrition, both from UC Berkeley. Ms. Brainin-Rodriguez previously worked at Highland Hospital's Department of Obstetrics and Gynecology, the SF WIC Program, the Stanford University Student Health Center and Health Improvement Program and the SF CHDP Program. She has also taught at UCSF School of Nursing, SF State University, City College of SF, St. Mary's College, Universidad Centroamericana in Nicaragua and UC Berkeley Extension. Over the last 22 years, Ms. Brainin-Rodriguez has given hundreds of presentations for lay and professional audiences on the role of nutrition in health promotion. She has also provided individual nutrition consultation to over 8,000 people seeking to improve their nutritional well-being.

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Dr. Brindis is the Senior Regional Cardiology Advisor for Northern California Kaiser and a Clinical Professor of Medicine at the University of California, San Francisco. Dr. Brindis graduated from MIT in 1970 after which he obtained a master's degree in Public Health from UCLA in 1972. He graduated from Emory Medical School, Summa Cum Laude in 1977 with elected membership in Alpha Omega Alpha. All of his graduate medical training was performed at UCSF as a Resident and Chief Resident in Internal

Medicine and also as a Cardiology Fellow. Dr. Brindis is a practicing interventional cardiologist with an active practice of consultative cardiology. His major interest is in process measures and outcomes assessment in cardiovascular care and this has led to helping to create and implement various Cardiovascular Guidelines for Northern California Kaiser. Dr. Brindis serves on the Board of Trustees of the American College of Cardiology (ACC). He recently completed his term as ACC Governor of Northern California and is Past President of the California Chapter of the ACC. Dr. Brindis is the present Chair of the ACC Planning and Management Task Force for the National Cardiovascular Registry (ACC-NCDR). He Chairs the ACC Quality Strategic Oversight Committee and Co-Chairs the NCDR Publications and Development Sub-Committee. Other ACC national committees that Dr. Brindis presently is actively participating in include the Advocacy Committee and the Task Force to Develop a Cardiac Catheterization Laboratory CQI Toolkit. Dr. Brindis is an active AHA volunteer and has served on the California Affiliate Board and previously as President of the San Francisco Division. He serves on the executive committee of CRUSADE, a national registry for Acute Coronary Syndromes. Dr. Brindis was appointed to serve on the Cardiac Advisory Board of the State of California OSHPD initiative overseeing public reporting of hospital and physician specific CABG mortality. He also presently serves on the National VA Blue Ribbon Advisory Panel for Cardiovascular Disease.

Name:	David Ghilarducci, MD
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Dr. Ghilarducci is the Medical Director of the Santa Clara County EMS Agency and an Emergency Medicine Physician at Kaiser Permanente. Dr. Ghilarducci attended the Medical College of Wisconsin, Milwaukee WI and Michigan State University (emergency medicine residency/chief resident). His research interests/publications include hazardous materials and WMD disaster management. In addition, he is a Fire Captain/Acting Battalion Chief, with the Santa Clara County Fire Department and a Hazardous Materials Specialist.

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Khati Hendry, MD is a family physician and Medical Director at the Community Health Center Network in Alameda County, California. Her clinical practice is at La Clinica de la Raza, where she served as Medical Director for eight years, and as physician champion for the Diabetes Collaborative Team. Based on that experience, she collaborated with the Network, where they developed an improvement model for asthma and cardiovascular disease. Current projects include Network-wide quality improvement and data initiatives, building infrastructure for a Practice-Based Research Network. She is a graduate of Harvard College, the University of California San Francisco Medical School, and Providence Family Practice Residency. She serves on the Pacific West Cluster National Health Disparities Steering Committee, is a Fellow in the California Health Care Foundation California Health Care Leadership Program, and an Associate Clinical Professor at the University of California San Francisco.

Name: Dick Hodgson
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Dick Hodgson is Vice President of Policy and Planning for the San Francisco Community Clinic Consortium (SFCCC). SFCCC is an organization of nine neighborhood-based nonprofit community health centers serving San Francisco's culturally and linguistically diverse communities. These community health centers joined together over twenty years ago to have a collective voice in community and government affairs and to share ideas and resources. Prior to joining SFCCC, Mr. Hodgson was a senior analyst in the San Francisco Department of Public Health Policy and Planning unit, Director of Planning for the University of Maryland School of Medicine, and Director of Medical Sciences Planning for the UC Davis School of Medicine/ Medical Center. He has worked in health policy for over twenty years.

Name: James Letchworth
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James Letchworth graduated from nursing school in 1972. He has worked for Kaiser since 1982. His nursing background includes ICU/CCU, ER and Medical/Surgical. He has worked in Adult Outpatient Medicine since 1987. Mr. Letchworth has been the

MULTIFIT Cardiac Rehab Coordinator at San Francisco since 1995. MULTIFIT is a telephone–based program which focuses on smoking cessation, diet counseling, exercise counseling and cholesterol management.

Name:	Antonio P. Linares, MD, FAAFP
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Dr. Linares is the Medical Director for Quality Improvement at Lumetra, Inc., the largest federally designated Quality Improvement Organization (QIO) in the country and oversees the quality of care for over four million Medicare beneficiaries in California. Dr. Linares serves as Lumetra's senior physician leader in the statewide effort to accelerate adoption of electronic health records in physician offices and support practice redesign to improve chronic care outcomes. Prior to joining Lumetra, Dr. Linares was the founding Medical Advisor for a new California state agency, The Department of Managed Health Care. The department was created because of an increased demand to hold HMO's and managed care systems more accountable to quality care by implementing an external review program. Over the past 16 years, Dr. Linares has served in executive leadership roles for hospital- based systems, national managed care plans, and integrated provider organizations He received a medical degree from Case Western Reserve University School of Medicine and completed a Family Practice Residency at the University of California, Davis Medical Center. Dr. Linares served in the Public Health Service and National Health Service Corps. Dr. Linares is currently on the adjunct faculty at the Center for Health Policy at the Stanford University School of Medicine and the Primary Care Health Policy Research Center at the University of California, Davis School of Medicine.

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Dr. McCarthy graduated from Johns Hopkins Medical School, completed a neurology residency at the University of Pennsylvania Medical Center in Philadelphia and a neurology fellowship at UCSF. Currently, he is a practicing neurologist in Marin County

and serves as Chief of the Neurology Department and Chief of Quality Management at Kaiser San Rafael Medical Center in Marin County. Dr. McCarthy is a member of the Board of Directors of the Permanente Medical Group (Kaiser Permanente) and a member of the Board of Directors of the American Heart Association (North Bay Division). He volunteers as an Assistant Clinical Professor of Neurology at UCSF. His passions are improving prevention and treatment of stroke and promoting evidence-based treatment of stroke.

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Biography unavailable.

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Karen Robertson Strain has worked in the health care field for 20 years, beginning her career as an emergency medical technician. Most recently, Ms. Strain is employed by the American Heart Association as a Program Director, working with the school district to implement CPR training in the 9th grade.

Name:	Charles J. Toeniskoetter
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Mr. Toeniskoetter is a stroke survivor and co-founder of the Stroke Awareness Foundation.

APPENDICES

Appendix 1: **Assembly Bill 1220 (Berg) and Highlights**

I. AB 1220 TEXT

BILL NUMBER: AB 1220 CHAPTERED
BILL TEXT

CHAPTER 395
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AMENDED IN SENATE AUGUST 18, 2003
AMENDED IN SENATE JULY 15, 2003
AMENDED IN ASSEMBLY JUNE 2, 2003
AMENDED IN ASSEMBLY MAY 6, 2003
AMENDED IN ASSEMBLY APRIL 10, 2003

INTRODUCED BY Assembly Member Berg
(Principal coauthor: Assembly Member Cohn)
(Coauthors: Senators Aanestad, Alarcon, Chesbro, Florez, Kuehl, Ortiz, Romero, Vasconcellos, and Vincent)

FEBRUARY 21, 2003

An act to add and repeal Section 104141 of the Health and Safety Code, relating to disease prevention.

LEGISLATIVE COUNSEL'S DIGEST

AB 1220, Berg. Heart disease and stroke prevention.

Existing law requires the State Department of Health Services to administer various programs related to disease prevention and health promotion, including a program for the control of high blood pressure.

This bill would create the Heart Disease and Stroke Prevention and Treatment Task Force within the department. The task force would be composed of 12 members, as specified, and would be required to perform a number of duties, including the creation of a Heart Disease and Stroke Prevention and Treatment State Master Plan. This bill would require the task force, by November 1, 2005, to submit the master plan to the Legislature, the Governor, and the department. This bill would also make implementation of its provisions contingent upon the receipt of private funding in an amount sufficient to fund the entire cost of the operation of the task force and costs associated with completing the requirements imposed by this bill, as determined by the department. These provisions would become

inoperative March 1, 2006, and would be repealed January 1, 2007.

THE PEOPLE OF THE STATE OF CALIFORNIA DO ENACT AS FOLLOWS:

SECTION 1. The Legislature finds and declares all of the following:

(a) Cardiovascular disease is the number one cause of death and disability nationally.

(b) Heart disease alone is the number one killer, and stroke is the number three killer, of Californians.

(c) More people die each year of cardiovascular disease than of the next five leading causes of death combined.

(d) This year the economic burden on the nation due to heart diseases and stroke is estimated to be over three hundred and fifty billion dollars ($350,000,000,000).

(e) A heart disease and stroke prevention and treatment state master plan is needed to reduce the morbidity, mortality, and economic burden of heart disease and stroke in the state. A master plan is a vital step toward enabling the state to draw down needed federal funds for future activities in this area.

SEC. 2. Section 104141 is added to the Health and Safety Code, to read:

104141. (a) The Heart Disease and Stroke Prevention and Treatment Task Force is hereby created in the department.

(b) The task force shall be comprised of 12 members, as follows, who have demonstrated interest in heart disease or stroke:

(1) Three members appointed by the Speaker of the Assembly, as follows:

(A) One member representing a volunteer health organization dedicated to research and prevention of heart disease and stroke.

(B) One practicing physician with expertise in research, prevention, or treatment of stroke victims.

(C) One hospital administrator.

(2) Three members appointed by the Senate Committee on Rules, as follows:

(A) One representative of a population disproportionately affected by heart disease and stroke.

(B) One practicing physician with expertise in research, prevention, or treatment of cardiovascular disease.

(C) One representative of a health care organization.

(3) Six members appointed by the Governor, as follows:

(A) One heart disease survivor.

(B) One stroke survivor.

(C) One registered nurse.

(D) One representative of a local health department.

(E) One member of a university facility with expertise in programs intended to reduce the rate of heart disease and stroke.

(F) One registered dietitian with experience in population based programs.

(c) (1) Members of the task force shall be appointed on or before

March 1, 2004.

(2) Members shall serve without compensation, but shall be reimbursed for necessary travel expenses incurred in the performance of task force duties.

(3) On or before June 1, 2004, the task force shall meet and establish operating procedures.

(4) A majority of the task force shall constitute a quorum for the transaction of business.

(5) The task force shall be headed by a chairperson, selected by the task force from among its members.

(d) The duties of the task force shall include, but not be limited to, all of the following:

(1) Creating a comprehensive Heart Disease and Stroke Prevention and Treatment State Master Plan that contains recommendations to the Legislature, the Governor, and the department. The master plan shall address changes to existing law, regulations, programs, services, and policies for the purpose of improving heart disease and stroke prevention and treatment in the state.

(2) Synthesizing existing information on the incidence and causes of heart disease and stroke deaths and risk factors to establish a profile of these deaths and risk factors in the state for the purpose of developing the master plan.

(3) Publicizing the profile of heart disease and stroke deaths and persons at risk in the state, and methods of prevention of heart disease and strokes.

(4) Identifying priority strategies that are effective in preventing and controlling, and treating persons at risk of, heart disease and stroke.

(5) Receiving and considering reports, data, and testimony from individuals, local health departments, community-based organizations, voluntary health organizations, and other public and private organizations statewide in order to assess opportunities for collaboration, as well as to identify gaps in heart disease and stroke prevention and treatment in the state.

(e) On or before November 1, 2005, the task force shall submit its plan to the Legislature, the Governor, and the department. Prior to issuing the plan, the task force may issue recommendations, as it deems necessary. Once the plan is submitted, the task force may revise and update the plan as necessary due to medical advances or other relevant information.

(f) The department shall provide staff support to the task force, and may apply for, accept, and spend any grants and gifts from any source, public or private, to support the requirements of this section.

(g) Implementation of this section shall be contingent upon the receipt of private funding in an amount sufficient to fund the entire cost of the operation of the task force and costs associated with completing the requirements imposed by this section, as determined by the department.

(h) This section shall become inoperative on March 1, 2006, and, as of January 1, 2007, is repealed, unless a later enacted statute, that becomes operative on or before January 1, 2007, deletes or

extends the dates on which it becomes inoperative and is repealed.

AB 1220 HIGHLIGHTS

- Exciting new legislation has put heart disease and stroke on the radar screen for California leaders. AB 1220, introduced in February 2003, by Assemblywoman Patty Berg, (D), was signed into law September 16, 2003, by the Governor. It became effective on January 1, 2004.
- The new law mandates the California Department of Health Services, California Heart Disease and Stroke Prevention Program (CHDSP) to assist a 12-member Task Force to develop a State Master Plan for Heart Disease and Stroke Prevention and Treatment. The State Master Plan will put CHDSP in a better position to receive funding from the Centers of Disease Control and Prevention (CDC).
- Under the provisions of AB 1220, all funding to support the convening of the Task Force, and the development of the State Master Plan must come from private sources. Support has come from the American Heart Association, AstraZeneca (in the form of an unrestricted educational grant) and Kaiser Permanente.
- The Task Force will be appointed by the Speaker of the Assembly (3 members); the Senate Committee on Rules (3 members); and by the Governor (6 members). They will include: one member representing a volunteer health organization dedicated to research and prevention of heart disease and stroke; one practicing physician with expertise in research, prevention or treatment of stroke victims; one hospital administrator; one representative of a population disproportionately affected by heart disease and stroke; one practicing physician with expertise in research, prevention, or treatment of cardiovascular disease; one representative of a health care organization; one heart disease survivor; one stroke survivor; one registered nurse; one representative of a local health department; one member of a university facility with expertise in programs intended to reduce the rate of heart disease and stroke, and one registered dietitian with experience in population based programs.
- CHDSP is planning to sponsor Public Forums on Heart Disease and Stroke in seven California cities: Eureka, Sacramento, San Francisco, Fresno,
- Los Angeles, San Bernardino/Riverside and San Diego in January, February and March 2004. At their first meeting, the Task Force will receive a report detailing input that has been gathered from the public and experts at these forums. This will afford them a running start on the development of the Plan.
- AB 1220 begins a continuum of education for the California Governor and legislature. In the first phase, during the legislative hearing of 2003, they became familiar with the burden of heart disease and stroke in California; in the second phase they will appoint experts to the Task Force in order to develop a Master Plan for the state; and in the third phase the California Governor and legislature will review the State Master Plan and the steps that need to be taken to reduce the burden of heart disease and stroke in California.

Appendix 2: **CHDSP Contact Information**

California Department of Health Services
California Heart Disease and Stroke Prevention Program

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Sacramento, CA 95899-7413

Physical Address:
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Sacramento CA 95814

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lchaput@dhs.ca.gov

Nan Pheatt, MPH
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npheatt@dhs.ca.gov

Melba Hinojosa, RN, MA
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FAX 552-9911
mhinojos@dhs.ca.gov

Appendix 3: **Glossary and Acronyms**

5 a Day
The California Department of Health Services' "5 A Day" program was developed in 1991 as a partnership between the National Cancer Institute and the Produce for Better Health Foundation. The program's mission is to increase public awareness about the importance of eating more fruits and vegetables (www.dhs.ca.gov/ps/cdic/cpns/ca5aday).

Angiotensin-converting enzyme-inhibitors (ACE-I)
These drugs are used to control high blood pressure. The ACE inhibitors interfere with the body's production of angiotensin II, a chemical that causes the arteries to constrict.

Active Living Network
The Active Living Network is supported by The Robert Wood Johnson Foundation and administered by San Diego State University. The Active Living Network is part of a coordinated response to find innovative approaches for integrating physical activity into daily life. Instead of thinking about obesity as an individual health problem, the focus is on how the built environment — including neighborhoods, transportation systems, buildings, parks and open space — can promote more active lives (http://www.activelivingresearch.org).

American Heart Association (AHA)
(www.americanheart.org).

Angioplasty
Angioplasty is a technique that opens coronary arteries blocked by plaque. Plaque is the build-up of cholesterol and other fatty substances in an artery's inner lining.

American Stroke Association (ASA)
A division of the American Heart Association (www.stroke.org).

Adult Treatment Panel III (ATP III)
Cholesterol treatment guidelines from the National Cholesterol Education Program (NCEP) Expert Panel on Detection, Evaluation, and Treatment of High Blood Cholesterol in Adults (www.nhlbi.nih.gov.

Beta blockers
A class of antihypertensive medicines that work by reducing the heart rate and the heart's output of blood.

Body Mass Index (BMI)
BMI assesses your body weight relative to height. It's a useful, indirect measure of body composition because it correlates highly with body fat in most people. Weight in

kilograms is divided by height in meters squared (kg/m^2)
http://www.cdc.gov/nccdphp/dnpa/bmi/calc-bmi.htm.

California Legislation (www.ca.gov)

SB 101 (Chesboro) Introduced 1/29/03. Health Care Coverage: Substance Related Disorders.

SB 1821 (**Dunn)** Introduced 2/20/04. Tobacco products: Minimum Legal Age: Advertising, Display, and Distribution Limitations.

SB 1566 (Escutia) Introduced 2/19/04. Schools: Food and Beverage Standards.

AB 2200 (Hancock) Introduced 2/18/04. School Breakfast Program.

AB 2686 (**Jackson)** Introduced 2/20/04. National School Lunch Program.

SB 921 (Kuehl) Introduced 2/21/03 Single Payer Health Care Coverage.

California Healthcare Institute
The California Healthcare Institute is a non-profit, public policy research organization for California's biomedical industry (www.chi.org).

California Public Employees' Retirement System (CalPERS)
www.calpers.org.

California Cooperative Healthcare Reporting (CCHRI)
The CCHRI is a collaborative of health care purchasers, plans and providers and it works to collect and report standardized, reliable health plan and provider performance data, promote the use of accurate and comparable quality measures, and create efficiency in data collection. Ten health plans, representing over 85 percent of the commercial HMO population in California, participate in a variety of CCHRI data collection projects and many plans participate in several different projects (www.cchri.org).

Centers for Disease Control and Prevention (CDC)
CDC is an agency for the US Department of Health and Human Services. Its mission is to protect the health and safety of all Americans. CDC's national focus is the development and application of disease prevention and control policies and measures. www.cdc.gov.

CDC's "I Quit" Tobacco Prevention and Information Source
Cessation guide specifically for teens trying to quit smoking cigarettes or using smokeless tobacco.

California Heart Disease and Stroke Prevention Program (CHDSP)
A program of the California Department of Health Services, Prevention Services Division, Chronic Disease and Injury Control Section.

City of Fresno Council for Physical Fitness
This council attempts to increase all Fresno citizens' ability to access everyday opportunities for physical activity. The citizens' level of physical fitness is a key element of a healthy city and it can have a significant effect on a community's overall quality of life and productivity (www.getfitfresno.org).

Cardio Pulmonary Resuscitation (CPR)
Cardiopulmonary resuscitation is a method used to resuscitate someone whose heart has stopped beating. CPR uses a combination of rescue breathing and chest compressions to continue blood and oxygen circulation.

C-reactive protein
When systematic inflammation occurs in the body, C-reactive protein is one of the acute phase proteins that may be detected. Testing for CRP is a new diagnostic tool used to assess for CVD risk.

Federal Emergency Management Agency (FEMA)
FEMA's mission is to lead America to prepare for, prevent, respond to, and recover from disasters (www.fema.gov).

Farm to School Program
The California Farm to School Program offers schools the opportunity to procure fresh, local produce and incorporate school gardens and nutrition education in their curriculums.

Fostering Sustainable Behaviors
This site provides information about community-based social marketing to design and evaluate programs to foster sustainable behavior, articles, and reports on fostering sustainable behavior www.cbsm.com.

Guidelines Applied in Practice (GAP)
The American College of Cardiology Guidelines Applied in Practice Program is an effort to improve the quality of cardiovascular care by developing and bringing seventeen ACC/AHA practice guidelines to the point of care.

Get With the Guidelines
Get With The Guidelines^{SM} (2 programs, one for heart disease and one for stroke) are hospital-based quality improvement programs designed to help healthcare providers keep up-to-date on the most recent treatment guidelines for heart disease and stroke. These programs encourage a multidisciplinary approach to risk-factor management, linking cardiologists, neurologists, primary care physicians, nurses, and pharmacists. It

also provides resources to build consensus and optimize treatment protocols. These programs were developed in conjunction with the American Heart Association and the American Stroke Association (www.americanheart.org).

Go Red For Women
An American Heart Association campaign to educate women, the general public, and healthcare professionals about the prevalence of heart disease and stroke among women. Go Red For Women helps women to learn about heart disease and stroke and how to take positive action to prevent acute events (www.americanheart.org).

Health Resources and Services Administration (HRSA)
HRSA's mission is to improve and expand access to quality health care for all, including reducing health disparities among ethnic and racial groups. (www.hrsa.gov).

Healthy Families Program
This is a federally funded California program. Healthy Families Program offers low cost insurance for children and teens up to age 19. It provides health, dental and vision coverage to children who meet the program rules and do not qualify for free Medi-Cal (www.healthyfamilies.ca.gov).

Healthy People 2010
National guidelines that describe the nation's health objectives for the decade. The CDC plays a major leadership role in carrying out the goals set forward in this initiative.

Health Insurance Portability and Accountability Act (HIPPA)
HIPPA are security and privacy provisions of the federal law that is applicable to health information created or maintained by health care providers who engage in certain electronic transactions, health plans, and health care clearinghouses. (http://hhs.gov/ocr/hipaa/bkgrnd.html).

Heart Power!
HeartPower! Online is the American Heart Association's curriculum-based program for teaching youth about how the heart works and how to keep it healthy for a lifetime. Nutrition, physical activity, and living tobacco-free all are vital in maintaining a healthy heart (www.americanheart.org).
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Heart Saver CPR
This course, offered through the American Heart Association, teaches students the basic techniques of adult cardiopulmonary resuscitation and how to use an automated external defibrillator. Students also learn about using barrier devices in CPR and giving first aid for choking. The course teaches how to recognize the signs of four major emergencies: heart attack, stroke, cardiac arrest and choking (www.americanheart.org).

Heart Smart Cities
California Department of Health Services provided grants in 1997-2000 to cities with high rates of death from heart disease. The object of the program was to educate the general public about the problem of heart disease, to educate local leaders on prevention policies, and to implement local projects to increase access to physical activity and healthy foods in low-income neighborhoods.

Homocysteine
Homocysteine is an amino acid found in the blood. Too much homocysteine is related to a higher risk of coronary heart disease, stroke and peripheral vascular disease.

Humboldt Bay Area Bike Map
www.rcaa.org/bikemap

Jackson Mississippi Heart Study
A study that examines the factors that influence the development of cardiovascular disease in African-American men and women. The goal of the Jackson Heart Study is to identify factors that cause African-Americans to be at higher risk for the development of cardiovascular disease. The Jackson Heart Study is a continuation of the successful work of the Atherosclerosis Risk in Communities (ARIC) Study, a study conducted in Jackson as well as in three other U.S. cities (http://ccaix.jsums.edu/~jhs/).

Joint Commission on Accreditation of Healthcare Organizations (JCAHO)
The Joint Commission is an independent, not-for-profit agency governed by a board that includes physicians, nurses, and consumers. JCAHO sets standards by which health care quality is measured and the Commission's mission is to continuously improve the safety and quality of care provided to the public through the provision of health care accreditation and related services that support performance improvement in health care organizations (www.jcaho.org).

Joint National Committee (JNC VII)
Joint National Committee on Prevention, Detection, Evaluation, and Treatment of High Blood Pressure includes recommendations for the assessment of overall cardiovascular risk and the need for active antihypertensive drug therapy (www.nhlbi.nih.gov/guidelines/hypertension/jncintro.htm).

Medicaid Quality Control Pilot
Quality assessment and improvement projects under the auspices of the Centers for Medicare & Medicaid Services, a Federal agency within the U.S. Department of Health and Human Services (www.cms.hhs.gov).

National Standards on Culturally and Linguistically Appropriate Services (CLAS)
United States Health and Human Services, Office of Minority Health, The Center for Linguistic and Cultural Competence in Health Care developed 14 individual standards for culturally and linguistically appropriate services that healthcare agencies can use to

guide the development of their programs. The development, methodology and analysis undertaken to create the national standards can be found online at: http://www.omhrc.gov/omh/programs/2pgprograms/finalreport.pdf.

National Committee for Quality Assurance (NCQA)
NCQA's goal is to improve the quality of health care delivered to people everywhere by the development of performance measures, quality of care report cards, and accreditation standards for healthcare maintenance organizations (www.ncqa.org).

National Institute of Neurological Disorders and Stroke (NINDS--tPA Stroke)
The National Institute of Neurological Disorders and Stroke, one of the National Institutes of Health, sponsors and conducts research and research training to learn about the healthy brain and to discover and disseminate information on ways to prevent, cure and treat neurological and neuromuscular disorders and stroke. NINDS has supported clinical trials to assess the benefits of aspirin and warfarin (an anticoagulant) for stroke prevention in specific at-risk populations (www.ninds.nih.gov).

National Registry of Myocardial Infarction (NRMI)
NRMI is sponsored by Genentech, Inc. and it is one of the largest observational studies of acute myocardial infarction ((www.nrmi.org).

North Karelia Project in Finland
The North Karelia Project was started in 1971 to address the exceptionally high coronary heart disease mortality rates in the area. Local and national experts coordinated with the World Health Organization to develop and implement this research project and to implement comprehensive intervention programs to combat heart disease and stroke. The results of this 25-year study indicate that prevention activities can have a major impact on risk factors to help reduce the incidence of heart disease and stroke (http://www.ktl.fi/eteo/cindi/northkarelia.html).

On the Move Program
The Fresno County Office of Education is implementing a program to reduce the high rates of obesity among school children. The health services staff created a program that reaches out to obese students using a mobile health center. The center staff will provide health assessments, chronic disease assessments, counseling, and educated related to physical activity and good nutrition. (www.fcoe.k12.ca.us).

Public Access to Defibrillation (PAD Program)
This programs aims to make automated external defibrillators available in public and/or private places where large numbers of people gather or people who are at high risk for heart attacks live (see www.americanheart.org).

Plant a Row
Plant A Row is a nationwide, people-to-people program sponsored locally by University of California Cooperative Extension Master Gardeners. The goal is to connect home

gardeners who grow extra fruits and vegetables with those in the community who are in need of that nutritious food.

Preferred Provider Organization (PPO)
Preferred Provider Organization.

Project Leaders Encouraging Activity and Nutrition (Project LEAN)
The goal of this program is to help Californians be more physically active, consumers of healthy foods, and live in communities that support healthy lifestyles.

Racial and Ethnic Approaches to Community Health (REACH 2010)
Racial and Ethnic Approaches to Community Health (REACH) 2010 is the initiative aimed at eliminating disparities in health status experienced by ethnic minority populations in key health areas. This initiative is part of *Healthy People 2010* (http://www.cdc.gov/reach2010).

School Health Index
The Centers for Disease Control and Prevention, Division of Adolescent and School Health, has published the third edition of the *School Health Index: A Self-Assessment and Planning Guide*. This version includes information that will allow schools to address their policies and programs related to safety (unintentional injury and violence prevention) in addition to the physical activity, nutrition, and tobacco-free lifestyle issues addressed in the previous editions (http://www.cdc.gov/HealthyYouth/SHI).

Screening, Brief Intervention and Referral (SBIR)
Program by the Substance Abuse and Mental Health Services Administration designed to expand and enhance State substance abuse treatment service systems (www.samsa.gov).

Smart Growth
Smart Growth America is a coalition of advocacy organizations that have a stake in how metropolitan expansion affects the environment, Americans' quality of life and economic sustainability (http://www.smartgrowthamerica.com).

Statins
LDL cholesterol drug therapy. Statins is the short name for this class of drugs that are HMG CoA reductase inhibitors . These powerful drugs help higher risk patients reach their target cholesterol goal. Other cholesterol treatment drugs such as bile acid sequestrants, nicotinic acid, and some fibrates also can moderately lower LDL levels.

Transient Ischemic Attacks (TIA)
Transient ischemic attacks are "warning strokes" or "mini-strokes" that produces stroke-like symptoms but no lasting damage. Recognizing and treating TIAs can reduce the risk of a major stroke.

Therapeutic Lifestyle Changes (TLC)
Includes reduced intake of saturated fats and cholesterol, therapeutic dietary options to enhance LDL lowering (plant stanols/sterols and increased viscous fiber), weight control, and increased physical activity.

Tissue Plasminogen Activator (tPA)
tPA is a thrombolytic agent (clot-busting drug). It is approved for use in certain patients having a heart attack or stroke. The drug can dissolve blood clots, which cause most heart attacks and strokes.

World Health Organization (WHO)
WHO is the United Nations specialized agency for health. (www.who.int/en).

Appendix 4: **Public Forum Materials**

Questions for Heart Disease and Stroke Public Forums

1. What are the three most important changes in California that need to be made in order to reduce death and disability from heart disease and stroke?

2. What do people in California need to learn about heart disease and stroke? What do physicians and healthcare professionals need to learn about heart disease and stroke?

3. What needs to happen in California schools, workplaces, and communities to prevent heart disease and stroke?

4. What needs to change in the healthcare setting to improve a) prevention of heart disease and stroke, and b) quality of treatment delivered to patients with heart disease or stroke?

5. How can we reduce health disparities in heart disease and stroke?

Panelist Biographical Information

(Please FAX to Center for Collaborative Planning (CCP), the professional facilitators assisting CHSDP.

Name:_____

Title: _____

Area of Expertise: _____

Affiliation: _____

Mailing Address: _____

Email Address: _____

Telephone: _____

Brief Biography:

Audience Member's Contact and Comment Form
(Forms without complete contact information will not be used)

Name:_____

Title: _____

Area of Expertise: _____

Affiliation: _____

Mailing Address: _____

Email Address: _____

Telephone Number:_____

Questions for Heart Disease and Stroke Public Forums

What are the three most important changes in California that need to be made in order to reduce death and disability from heart disease and stroke? COMMENTS

What do people in California need to learn about heart disease and stroke? What do physicians and healthcare professionals need to learn about heart disease and stroke? COMMENTS

What needs to happen in California schools, workplaces, and communities to prevent heart disease and stroke? COMMENTS

What needs to change in the healthcare setting to improve a) prevention of heart disease and stroke, and b) quality of treatment delivered to patients with heart disease or stroke? COMMENTS

How can we reduce health disparities in heart disease and stroke? COMMENTS

AUDIENCE INFORMATION PACKET

Purpose of the Forum

- AB 1220, Heart Disease and Stroke Prevention, requires the establishment of a statewide Heart Disease and Stroke Prevention and Treatment Task Force. This Task Force, staffed by the California Heart Disease and Stroke Prevention (CHDSP) Program, will develop a State Master Plan to reduce morbidity and mortality and the economic burden of heart disease and stroke.
- This public forum will provide critical local input for the state-appointed Task Force.
- Seven regional public forums will be held throughout the State (**Eureka, Fresno, Sacramento, San Francisco, San Bernardino, Los Angeles** and **San Diego**) to provide the Task Force with immediate input from various regional stakeholders on heart disease and stroke in the state.
- Audience members' written and verbal comments, as well as comments from the panelists, will be included in the public forum report. A final summary report of all seven public forums will be submitted to the newly convened Task Force.

Major Underwriters

- American Heart Association
- AstraZeneca
- Kaiser Permanente

Organizers

- California Heart Disease and Stroke Prevention Program

Panelists

- Each panelist will be introduced at the beginning of the Public Forum (name, current affiliation and title).

Forum Structure

- At all seven public forums across the state, the same five questions will be asked. After the panelists are introduced, twenty minutes will be allowed for each of the five questions. All panelists will have the opportunity to provide comments on each of the five questions so answers must be brief. After all five questions have been asked and commented upon, there will be a 15-minute "open mike" opportunity for the panelists to add comments.

Respect

- The California Heart Disease and Stroke Prevention program staff acknowledge and respect the fact that this is your community. You live and work here, know the

strengths and weaknesses of the community, and we appreciate your attendance and value your opinions.

- Everyone in attendance here today will have the opportunity to provide comments, either verbally or in writing.
- Due to time constraints, testimony and comments must be limited to two minutes each.

Audience Participation and Comments

- During the last twenty minutes of the forum, public comments are encouraged and welcomed. Each audience member who wants to provide verbal or written comments must complete an "Audience Member's Contact and Comment Form".
- Individuals may submit written comments to the Department of Health Services in one of two ways:

1. Complete the "Audience Member's Contact and Comment Form"; these forms will be collected at the end of the forum.
2. Send an email directly to Melba Hinojosa, RN, MA, Program Specialist with the California Department of Health Services, Heart Disease and Stroke Prevention Program, at mhinojos@dhs.ca.gov within one week of the public forum. Along with your comments, please provide complete information about yourself (name, title, affiliation, area of expertise, mailing address, phone number, and email address.)

PANELIST INFORMATION PACKET

Purpose of the Forum

- AB 1220, Heart Disease and Stroke Prevention requires establishment of a statewide Heart Disease and Stroke Prevention and Treatment Task Force. This Task Force, staffed by the California Heart Disease and Stroke Program (CHDSP), will develop a State Master Plan to reduce morbidity and mortality and the economic burden of heart disease and stroke.
- This public forum will provide critical local input to this state-appointed Task Force.
- Seven regional public forums will be held throughout the State (**Eureka, Fresno, Sacramento, San Francisco, San Bernardino, Los Angeles** and **San Diego)** to provide the Task Force with immediate input from various regional stakeholders on heart disease and stroke in the state.
- Panelists' comments, as well as comments from the public, will be compiled in a site report, and a final report will be submitted to the newly convened Task Force.

Major Underwriters

- American Heart Association
- AstraZeneca
- Kaiser Permanente

Organizers

- California Heart Disease and Stroke Prevention Program

Panelists

- The facilitator will each panelist (name, current affiliation and title). Short panelist biographies are included in the audience information packet.

Forum Structure

- At all seven public forums across the state, the same five questions will be asked. After the panelists are introduced, twenty minutes for each of the five questions will be allowed. All panelists will have the opportunity to provide comments on each of the five questions so answers must be brief. After all five questions have been asked and commented upon, there will be a 15-minute "open mike" opportunity for the panelists to add comments.

- If you choose, you may also respond to the five questions in writing. Please submit your written comments to CHDSP staff to the address below or at the conclusion of the public forum.

Respect

- It is crucial that the facilitator keep the group on schedule. Please respect the time limits we are working under. CHDSP staff values your expert opinions and looks forward to learning about your ideas.

Audience Participation and Comments

- The audience members will be allowed to provide verbal comments during the last 20 minutes of the public forum.
- Audience members who do not want to give verbal comments may submit written comments to the Department of Health Services in one of two ways:

    1. Complete the "Audience Member's Contact and Comment Form"; these comments will be collected at the end of the forum.
    2. Comments can be emailed directly to Melba Hinojosa, RN, MA, Program Specialist with the California Department of Health Services, Heart Disease and Stroke Prevention Program, at mhinojos@dhs.ca.gov within one week of the public forum. Complete information must be included (name, title, affiliation, area of expertise, mailing address, phone number, and email address).

- The names of all audience members and panelists who provide verbal and written comments will be listed in the public forum report.

Inland Empire Public Forum, 2004